MEDI-CAL PROVIDER MANUAL

JUNE 2006 REVISION

CHP Provider Information Line: (Provider Issues)	**(626) 299-5599**
CHP Utilization Management/Case Management/Pharmacy Review Line: (During normal business hours)	**(626) 299-5539**
CHP Information/Authorization Line: (After normal business hours)	**(800) 832-6334**
CHP Call Center: (Member Issues/Eligibility, Transfers)	**(800) 475-5550**

Note: This document was revised in June 2006 with the following changes/modifications:

QUICK REFERENCE TELEPHONE NUMBERS AND ADDRESSES. This section was updated to include current contact information for the Community Health Plan. Also, contact information was verified and updated for non-Community Health Plan organizations/agencies referenced in this section and throughout the Manual. Please note that the following pages were affected:

1. Cover Page
2. 1.2
3. 1.3
4. 1.4
5. 4.14
6. 6.9
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If you have specific questions or comments about any the information presented in this Manual, please call the CHP Provider Information Line at (626) 299-5599.

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Introduction

The County of Los Angeles-Department of Health Services' (DHS) Office of Managed Care (OMC) developed this manual to provide guidance to its Community Health Plan (CHP) Medi-Cal Managed Care Program (MMCP) providers. CHP is a Plan Partner to L.A. Care Health Plan (L.A. Care) in the MMCP within Los Angeles County. The CHP MMCP is one of several different CHP product lines. This manual is only for CHP MMCP providers.

The manual contains broad and specific operating requirements, procedures, and guidelines and was written to ensue that:

(1) all Knox-Keene, MMCP, and L.A. Care Health Plan requirements are met;
(2) high quality, coordinated, and culturally sensitive and linguistically competent services are provided;
(3) traditional and safety net providers deliver health care at the highest possible levels of participation.

This manual is not intended to replace the policies, procedures, and guidelines of the State Department of Health Services (SDHS), the State Department of Managed Health Care (DMHC), and other relevant entities such as medical professional licensing boards. CHP providers must also adhere to any policies, procedures, and guidelines of such entities, which are not stated in this manual, over which CHP does not have authority.

The manual will be updated periodically with revised information. Each DHS CHP County facility and/or contractor (Provider Group) has been provided with a copy of the most current version of the CHP provider manual, which they are required to copy and distribute to their active CHP network providers within ten (10) days of receipt. Additionally, they are to ensure that any new CHP network providers receive this same information within ten (10) days of their being placed on active status. Requests for additional copies of this manual or requests for an orientation/presentation on information presented in this manual should be made through your Provider Group. **If you have specific questions or comments about any the information presented in this manual, please call the CHP Provider Information Line at (626) 299-5599.**

The CHP looks forward to working with its network providers to ensure a successful outcome for all participants in this Managed Care System - the patients, the providers of care, and the Provider Groups.

(To the extent that any inconsistency or conflict exists between the language in the Contractor's Agreement with the County and this Provider Manual, the Agreement shall govern and prevail.)

QUICK REFERENCE TELEPHONE NUMBERS AND ADDRESSES
(Revised June 2006)

COMMUNITY HEALTH PLAN/OFFICE OF MANAGED CARE (CHP/OMC)

1000 South Fremont Avenue
Building A-9 East, 2nd Floor, Unit 4
Alhambra, California 91803-8859
Website: www.ladhs.org/chp

CHP Utilization Management/Case Management/ Pharmacy Review Line: (During normal business hours)	**(626) 299-5539**
CHP information/Authorization Line: (After normal business hours)	**(800) 832-6334**
CHP Call Center/Customer Services: (Member Issues/ Eligibility, Transfers)	**(800) 475-5550**
CHP Provider Information Line: (Provider Issues)	**(626) 299-5599**
Call for Care Telephone Line (Members/Subscribers may call the 800 number to contact the Nurse Advice Line and Audio Health Library)	**(800) 249-3619**

L.A. CARE HEALTH PLAN

555 W. Fifth Street, 29th Floor
Los Angeles, CA 90013-3036

(213) 694-1250 phone
(213) 694-1246 fax
e-mail: **provider@lacare.org**
website: **www.lacare.org**

L.A. Care Provider Network Services Line:	(866) 522-2736
L.A. Care Member Services Department:	(888) 452-2273

PLAN PARTNER PROVIDER INFORMATION LINES:

Community Health Plan	**(626) 299-5599**
Blue Cross of California	(888) 285-7801
UHP Healthcare	(800) 680-3491
Care 1st Health Plan	(626) 299-4299
Kaiser Permanente	(800) 464-4000

HOTLINES

Dept. of Managed Health Care - Consumer Affairs Hotline	(800) 400-0815
Child Protection Hotline	(800) 540-4000
Domestic Violence Hotline	(800) 978-3600
Elder Abuse Hotline	(800) 992-1660
Adult Protective Services (in home abuse)	(213) 351-5401

QUICK REFERENCE TELEPHONE NUMBERS AND ADDRESSES (continued) (Revised June 2006)

FRAUD REPORTING HOTLINES

SDHS Medi-Cal Fraud Hotline	(800) 822-6222
L.A. Care Compliance, Fraud & Abuse Hotline	(800) 400-4889
L.A. County Fraud Hotline	(800) 544-6861

MISCELLANEOUS

CCS:	California Children's Services 9320 South Telestar Avenue, Suite 226 El Monte, CA 91731	(800) 288-4584 (800) 924-1154 Fax
DMHC:	California Department of Managed Health Care 980 Ninth Street, Suite 500 Sacramento, CA 95814-2725	(916) 322-2078
	Toll-free Provider line: Consumer HMO Help Line: e-mail: **helpline@dmhc.ca.gov** **www.dmhc.ca.gov**	(877) 525-1295 (888) HMO-2219 or (800) 400-0815
CHDP:	Child Health and Disability Program Hqtrs. 9320 South Telestar Avenue, Suite 226 El Monte, CA 91731	(800) 993-2437 or (800) 993-CHDP (626) 569-9350 Fax
Lead Program	LA County Lead Program 5555 Ferguson Drive, Suite 210-02 City of Commerce, CA 90022	(800) LA-4-LEAD
SDHS:	State Department of Health Services Medi-Cal Managed Care Division 1501 Capitol Avenue MS 4400 P.O. Box 997413 Sacramento, CA 95899-7413	(916) 449-5000
Office of the Ombudsman		(888) 452-8609
State Fair Hearing:	Department of Social Services Administrative Adjudication Division 744 P Street, Mail Station 19-3733 Sacramento, CA 95814	(800) 952-5253

QUICK REFERENCE TELEPHONE NUMBERS AND ADDRESSES (continued)
(Revised June 2006)

TB Control	L.A. County Tuberculosis Control 2615 S. Grand Avenue, Room 507 Los Angeles, CA 90007	(213) 744-6160 phone (213) 749-0926 fax
WIC:	Women, Infants, & Children Nutritional Services Program Headquarters 12781 Schabarum Avenue Irwindale, CA 91706	(626) 856-6600
Mail Address:	PHFE WIC Program P.O. Box 900 Baldwin Park, CA 91706-6807	

DEFINITIONS OF KEY TERMS AND ACRONYMS

Appeal	A further request to reverse a denied service or claim.
Capitation	A fixed prepayment for services based on a per Member per month (PMPM) rate paid each month regardless of utilization.
Carved Out Services	(Wrap around) programs provide certain services that are not basic Plan covered benefits, but may be accessed through referral.
CCS	California Children Services
CHDP	Child Health and Disability Prevention Program
CHP	Community Health Plan
CM	Case Management
Covered Services	Those medically necessary medical, hospital, pharmaceutical, and other services, including emergency and urgent care services, which the CHP is responsible for providing, or arranging for the provision thereof.
CPSP	Comprehensive Perinatal Services Program
DHS	Department of Health Services. (When referred to in this manual, it means the Los Angeles County - Department of Health Services.)
Director	Refers to the Director of the County's Department of Health Services or his or her designee.
DMHC	Department of Managed Health Care (formerly the Department of Corporations). State agency responsible for regulating health plans.
Emergency Services	Twenty-four hour emergency care for Members who present with conditions that are manifested by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention may result in placing the health

DEFINITIONS OF KEY TERMS AND ACRONYMS (continued)

	of the individual or unborn child in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily organ or part. Emergency services also include care for an emergency psychiatric condition.
EPSDT	Early Prevention, Screening, Diagnosis, and Treatment Supplemental Services.
Fee-for-Service (FFS)	A negotiated rate which the CHP will pay for the provision of a service.
FQHC	Federally Qualified Health Center [defined in Section 1905(1)(2)(B) of the Social Security Act.]
Grievance	A grievance is the process used when a Member or a provider is dissatisfied with a Health Plan.
HCSP	Health Care Service Plan
HMO	Health Maintenance Organization
IHA	Initial Health Assessment. (Each newly enrolled Member must be provided an IHA by his or her Primary Care Physician within 120 days of enrollment.)
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
Knox-Keene Act	Knox-Keene Health Care Service Plan Act of 1975, as amended, and the rules and regulations promulgated by the DMHC.
L.A. Care	L.A. Care Health Plan
Linked Programs	Linked Programs provide certain services that are basic covered benefits, but may not be within the scope of the PCP.
Marketing	Any activity conducted to maintain or enhance membership whereby present or prospective Members are provided descriptive material about the Plan, sufficient to make an informed choice to remain or enroll as a Member.

DEFINITIONS OF KEY TERMS AND ACRONYMS (continued)

Medi-Cal	Federal and State-funded health care program established by Title IX of the Social Security Act, as amended, which is administered in California by SDHS.
Medi-Cal Member	Individual who is eligible for Medi-Cal and is enrolled in the L.A. Care Health Plan.
MOU	Memorandum of Understanding
Non-Covered Services	Those services that the CHP provider is not responsible for providing.
OMC	Office of Managed Care. Los Angeles County Department of Health Services office responsible for the management/ oversight of the following health care programs: CHP Medi-Cal, CHP Healthy Families Program, Temporary County Employees, and the Personal Assistance Services Council (PASC) Service Employees International Union (SEIU) PASC-SEIU Homecare Workers Health Care Plan.
Ombudsman	An individual, within SDHS, who investigates grievances, reports findings, and helps to achieve equitable settlements.
Out-of-Plan	Services rendered to Plan Members outside of the CHP's Services network of providers.
Provider Group	Independent Practice Associations (IPAs)/Medical Groups or DHS CHP County facilities.
Plan Member or Member	A Medi-Cal beneficiary who has been assigned to or has selected the CHP and who has been assigned to or has selected a CHP Contractor as his/her primary care provider.
Plan Participating Provider	A provider who is affiliated by either employment with the County or by contract with a CHP Contractor for the provision of health care services to Plan Members.
Primary Care Provider (PCP)	A physician whose area of medical practice is one of the five specialties designated by the SDHS as a primary care specialty. The five specialties are: General Medicine, Internal Medicine, Pediatrics, Obstetrics/Gynecology and Family Medicine.

DEFINITIONS OF KEY TERMS AND ACRONYMS (continued)

Primary Care Services	Professional medical services provided in a continuing relationship established with an individual or family group in order to provide: 1.) Surveillance of health needs; 2.) Access to comprehensive health care, including preventive services; 3.) Referral to other health professionals; and 4.) Health counseling and patient education.
QA/QI	Quality Assurance/Quality Improvement
Request for Assistance (RFA)	A Member's request to DMHC to intervene and provide assistance in bringing an unresolved grievance to a satisfactory resolution.
Safety Net Providers	Providers of comprehensive primary outpatient care or acute hospital inpatient services who provide services to a significant number of Medi-Cal and medically indigent patients in relation to the total number of patients they serve. They include: - Public and private disproportionate share hospitals (as defined by federal or state criteria) - Trauma centers (as defined by the local emergency medical services authority to be essential access emergency hospitals) - Facilities of the Los Angeles County DHS - Community health centers (including free and community clinics licensed under California Health and Safety Code Title 22) - Indian Health Centers - Children’s hospitals
SDHS	State Department of Health Services
Specialty Medical Services	Services including the provision of complex, specialized care with the necessary supportive ancillary services, and surgical care provided by a physician specialist.
Specialty Physicians	A Plan Participating Provider providing Specialty Services upon referral by a Primary Care Physician.

DEFINITIONS OF KEY TERMS AND ACRONYMS (continued)

State Fair Hearing	An administrative procedure for a Medi-Cal Member to present her/his grievance case directly to the State of California for resolution. A fair hearing may be requested at any time during the grievance process.
State/L.A. Care Medi-Cal Agreement	The agreement entered into by and between L.A. Care and SDHS under which L.A. Care has agreed to arrange for or provide health benefits under the Medi-Cal Agreement.
Traditional Providers	Traditional providers such as hospitals, individual physicians and provider groups, pharmacies, and other health care providers which provide health care services covered by CHP that have maintained a consistent commitment to serving Medi-Cal beneficiaries as part of their patient load and practices, as set forth below: - Individual physicians who have seen Medi-Cal patients who comprise at least 15% of the annual active patient workload for each of the preceding two years; - Provider Groups which see Medi-Cal patients who, on average, comprise 15% of the group's annual active patient workload for each of the preceding two years; - Hospitals that have an annual Medi-Cal patient load of at least 15% of the hospital's adjusted inpatient days for each of the preceding two years; - All other health care providers who have at least 15% of their annual patient care service units comprised of active Medi-Cal beneficiaries for each of the preceding two years; - Meet SDHS and Knox-Keene requirements. Traditional providers may be profit or non-profit entities and publicly or non-publicly owned and operated.

DEFINITIONS OF KEY TERMS AND ACRONYMS (continued)

Two-Plan Model	The State contracted with two health care service plans for the provision of Medi-Cal Managed Care In Los Angeles County. One of these plans (Local Initiative) was locally created and designated by the County's Board of Supervisors. The other plan (Commercial Plan) was an existing HMO selected by the State.
UM	Utilization Management
UR	Utilization Review
Urgent Care	Services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury.
WIC	Women, Infants, & Children Nutritional Services Program

SUMMARY OF YEAR 2001, 2002, & 2003 STATE LEGISLATION

The following information is provided to update all CHP Providers on some new key California legislative changes affecting health care service plans (health plans):

State Legislation that became effective in 2001:

Bill No.	Bill Summary
AB 12	Requires health plans to provide or authorize a second medical opinion when requested by an enrollee or the treating health professional.
AB 39	Requires health plans that provide outpatient prescription drug benefits to provide coverage for a variety of FDA-approved prescription contraceptive methods.
AB 55	Establishes an independent review system for resolving enrollee grievances against health plans, effective January 1, 2001.
AB 78	Transfers the responsibility for regulating health plans from the Department of Corporations to the Department of Managed Health Care within the Business, Transportation & Housing Agency, to become operative on July 1, 2000, or before by executive order.
AB 88	Requires health plans, on or after July 1, 2000, to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses for persons of any age and serious emotional disturbances of a child, under the same terms and conditions applied to other medical conditions.
AB 285	Provides that every health plan that provides telephone medical advice services to its enrollees and subscribers shall require that the staff employed to provide those services hold a valid license as a health care professional, as specified. Prohibits a health plan from operating or contracting with a telephone medical advice service that is not registered with the Department of Consumer Affairs.
AB 416	Prohibits a provider of health care from releasing medical information related to outpatient psychotherapy treatment to specified entities and individuals unless the entity or individual requesting the information submits a request that contains specified information and representations.

State Legislation that became effective in 2001 (continued)

AB 892	Requires health plans, on or after January 1, 2002, to provide hospice care services that are at a minimum equivalent to hospice care services provided by the federal Medicare program as part of basic health care services.
AB 1836	Expands existing law that allows medical information to be disclosed to a coroner.
SB 5	Requires health plans to provide coverage for the screening, diagnosis and treatment of breast cancer.
SB 21	Enacts the Managed Health Care Insurance Accountability Act of 1999, which requires health plans and managed care entities to have a duty of ordinary care to arrange for the provision of medically necessary health care services to subscribers and enrollees, as specified.
SB 59	Sets forth procedures and timeframes for health plans for reviewing and responding to authorization requests from providers for the provision of health care services to enrollees; requires the policies, procedures and processes that each health plan uses to prospectively, retrospectively, or concurrently review and approve, modify, delay or deny authorization requests to be filed with the Director of the Department of Managed Health Care for review and approval, and to be disclosed by the health plan to enrollees, providers and the public upon request; requires the Director of the Department of Managed Health Care to review a health plan's compliance with the bill as part of its periodic onsite medical survey of each health plan and to include a discussion of the compliance as part of its medical survey report; and requires health plans to disclose to the public, upon request, the criteria or guidelines used to determine whether to authorize, modify, or deny health care services.

State Legislation that became effective in 2001 (continued)

SB 64	Requires (1) health plans, except specialized health plans, to include coverage for certain specified equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes, and gestational diabetes as medically necessary, even if the items are available without a prescription, (2) health plans, except specialized health plans, that cover prescription benefits to include coverage for certain diabetes related prescription items if determined to be medically necessary, and (3) health plans to provide coverage for diabetes outpatient self-management training, education, and medical nutrition therapy and for additional training, education, and therapy, as specified.
SB 148	Requires health plans, on or after July 1, 2000, to provide coverage for the testing and treatment of phenylketonuria (PKU), including formulas and special food products.
SB 205	Requires, on or after July 1, 2000, coverage for all generally medically accepted cancer screening tests.
SB 349	Requires health plans to provide coverage for the additional screening, examination and evaluation of a patient to determine whether a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the emergency medical condition.
SB 559	Prohibits entities from inappropriately marketing and selling lists to other entities without the knowledge of the providers.
SB 1185	Amends the anti-discrimination provisions of the Knox-Keene Act relating to genetic characteristics to further clarify the definition of "genetic characteristics" and amends the Confidentiality of Medical Information Act to specify that this definition for "genetic characteristics" also applies to the provisions prohibiting disclosure by health plans of genetic test results contained in medical records.
SB 1903	Prohibits providers from disclosing Member confidential information to affiliates and subsidiaries. Also, adult patients can provide a written addendum to their medical records, not to exceed 250 words.
SB 2246	Addresses the disposal of medical records. When providers are not required to retain records, they should be destroyed by shredding, erasing, or otherwise modifying the information to make it unreadable or indecipherable.

State Legislation that become effective in 2002:

AB 207	Requires every health care service plan, that covers prescription drug benefits and issues a card to enrollees for claims processing purposes, to issue to each of its enrollees a uniform card containing uniform prescription drug information. Effective July 1, 2002.
AB 938	Requires health care service plans to provide, upon request, a list of contracting health care providers within an enrollee's or prospective enrollee's general geographic area with specific information about the providers. Also, requires plan disclosure forms to describe limitations and authorization requirements for accessing non-physician providers. Effective July 1, 2002.
SB 37	Requires health care service plans to cover routine patient care costs for enrollees participating in a cancer clinical trial, that meets specified requirements, if referred to the trial by the enrollee's treating physician who is providing covered health care services under contract with the health plan. Effective January 1, 2002.
SB 1219	Requires that the cervical cancer screening coverage currently required of health plans must include the conventional Pap test and the option of any cervical cancer screening test approved by the federal Food and Drug Administration, upon referral by the patient's health care provider. Effective January 1, 2002.

State Legislation that became effective in 2003

AB 715	Amends the Confidentiality of Medical Information Act to include a prohibition against the use of medical information for marketing purposes not necessary to provide health care services to the patient. "Marketing" is defined as "a communication about a product or service that encourages recipients of the communication to purchase or use the product or service."
AB 763	Modifies existing requirements that restrict the printing of an individual's social security number on any mailed materials, except in very limited circumstances. The new law would additionally prohibit a social security number that is otherwise permitted to be mailed from being printed, in whole or in part, on a postcard or other mailer not requiring an envelope or visible on the envelope or without the envelope having being opened.

State Legislation that became effective in 2003 (continued)

AB 1286	Contains a number of new and modified provisions designed to ensure continuity of care. The bill increased from 30 to 60 days the advance notice required to enrollees when a plan's contract with a provider group or acute care hospital, under certain circumstances, is about to terminate. The bill also requires the plan to file the proposed enrollee notice with the DMHC at least 75 days prior to the contract termination date. If the plan later reaches agreement with a terminated provider following issuance of the notice, the plan must offer enrollees the option to return to, or remain with, their current provider. Plans are also required to file by March 1, 2004, as a material modification a continuity of care policy for new enrollees. AB 1286 expands upon the conditions under which enrollees may continue care with terminated or non-contracted providers, and adds time periods during which the continuation shall last: e.g., continuing care for an acute condition shall last for the duration of the condition, continuing care for a pregnancy shall continue for the duration of the pregnancy and the immediate postpartum period, continuing care for a terminal illness shall continue for the duration of the illness, etc.
AB 1496	Expands the independent medical review program to allow for retrospective review in cases where prior authorization by the plan was not required or provided. Under this bill, DMHC-licensed PPO enrollees will be eligible for independent medical review when the plan denies payment for rendered services on the basis that they were not medically necessary.
AB 1628	Requires non-contracting hospitals to contact an enrollee's health care service plan to obtain the enrollee's medical record information prior to admitting the enrollee as an inpatient for post-stabilization care; transferring an enrollee to a non-contracting hospital for post-stabilization care; or providing post-stabilization care to an enrollee admitted for medically necessary care. The bill requires a non-contracting hospital that admits an enrollee who is not stabilized to contact the enrollee's health plan as soon as reasonably possible after the condition is stabilized. The bill prohibits a hospital that is required to contact the patient's health plan, and fails to do so, from billing the patient for post-stabilization care.

State Legislation that became effective in 2003 (continued)

SB 853	Requires the DMHC to adopt regulations by January 1, 2006 requiring all health plans to assess the linguistic needs of their enrollees, excluding Medi-Cal enrollees, and to provide for translation and interpretation services. Among other things, the regulations will require the translation of vital documents into indicated languages. "Vital documents" will include at least the following; applications; consent forms; letters regarding eligibility and participation criteria; notices pertaining to the denial, reduction, modification or termination of services and the right to file a grievance; and notices advising limited-English proficient Members of the availability of free language assistance. The regulations will also provide that a plan is in compliance if the plan is required to meet the same or similar standards by the Medi-Cal program, so long as the standards provide as much access to cultural and linguistic services as the standards established by SB 853 for an equal or higher number of enrollees.
SB 969	Requires plans that provide telephone medical advice services to ensure that only staff who are licensed, certified or registered in a specific health care profession provide medical advice to plan Members.

Resources for regulations related to health care plans in California can be accessed through the internet. All California Regulations can be accessed through **http://www.leginfo.ca.gov.**

Also, the California Department of Managed Health Care (DMHC) provides updates on regulations adopted by DMHC to implement managed care law. California Code of Regulations, Title 28, Division 1, Chapter 1, and Pending Regulations can be downloaded through the DMHC web site **http://www.hmohelp.ca.gov/library/regulations**.

ORGANIZATIONAL STRUCTURE - SECTION 2

Overview of CHP's Organizational Structure

The Office of Managed Care (OMC) is administratively responsible for all CHP managed care product lines. The OMC is also responsible for the development and maintenance of managed care policies, standards and guidelines, and coordinates the prepaid health plan contracting activities on behalf of the County of Los Angeles, Department of Health Services. The final accountability for the CHP rests with the Los Angeles County Board of Supervisors.

Overview of L.A. Care Health Plan's Organizational Structure

The organization of L.A. Care Health Plan (L.A. Care) flows from its Board of Governors. The Board of Governors is the policy-making body with legal and fiduciary responsibility for all aspects of L.A. Care. The Board delegates the operational management of L.A. Care to the L.A. Care executive management team, led by the chief executive officer and chief medical officer.

The Board of Governors consists of thirteen members that are nominated by various stakeholders and are then publicly appointed by a majority vote of the Los Angeles County Board of Supervisors.

Relationship of L.A. Care Health Plan with CHP

CHP is a Plan Partner participating with L.A. Care, the Local Health Initiative for Medi-Cal Managed Care in Los Angeles County. L.A. Care's Plan Partners are:

Community Health Plan
Blue Cross of California
UHP Healthcare
Care 1st Health Plan
Kaiser Permanente

CHP MEDI-CAL SERVICE AREA

The CHP Medi-Cal Service Area means the geographic area in which the CHP is licensed to provide or arrange for the provision of Health Care Services.

Effective September 28, 2001, the DMHC approved the CHP's application to expand its Medi-Cal Managed Care Program (MMCP) product line throughout all of Los Angeles County.

This expansion is significant as it allows CHP to:

provide its MMCP beneficiaries with greater access to health care services throughout the entire County;

expand its MMCP provider network into previously excluded zip codes;

market its MMCP product line in all 12 DMHC Regions.

MEMBER SERVICES - SECTION 3

MEMBER SERVICES OVERVIEW

CHP's Member Services Section has Plan-wide responsibility for ensuring the Provider Group satellite offices comply with and uniformly apply external regulators' Member Services mandates that are designed to protect health care consumers. In support of the Plan's quality improvement/management efforts, Member Services administrative oversight is accomplished for example by developing and implementing Member Services policies and procedures to meet requirements of State and Federal laws; by operationalizing new Provider Group's Member Services processes; managing the Plan's Grievance Program for compliance with Department of Managed Health Care and other State regulations; conducting due diligence, annual, and independent provider Member Services site reviews in support of Medical Administration's Quality Improvement/Quality Management Program; preparing network Provider Groups for audits by external agencies; managing a Member Services training program for provider staff; developing Member materials that meet State requirements and the cultural and linguistic needs of Plan Members; and providing network Provider Groups with Member Services related administrative support which ensures successful partnerships with the Plan and L.A. Care.

Expansion of Member Services Network and Provision of Training

The CHP Member Services Training Program provides a comprehensive curriculum which increases attendees knowledge with regard to Member Services policies, guidelines, and regulations; CHP Member Services practices; Member Services processes; State member grievance compliance requirements, and L.A. Care Member Services contractual requirements and performance standards. A new Provider Group will receive Plan Member Services materials and on-site training for designated Member Services staff/liaison(s).

Provider Group/Provider Site Reviews

In conjunction with Medical Administration, each Provider Group and PCP location will be reviewed for compliance with existing Member Services requirements. As warranted, corrective action plans will be developed, implemented and monitored by Member Services. (Refer to Quality Management (QM) - Section 9 of this manual.)

CHP Call Center

CHP Customer Service Representatives are available at the CHP Call Center to provide Member Services support to network Provider Groups and PCPs. The CHP Call Center should be contacted directly if assistance is needed to address issues and/or concerns

MEMBER SERVICES (continued)

related to the L.A. Care and CHP Member Services, membership, and grievance processes. The CHP Call Center may be reached at 1(800) 475-5550.

The Provider Groups and PCPs must make available to Plan Members, designated staff to assist Members with questions, concerns, and grievances while they are in the PCP's office. This staff must also be familiar with CHP's Member Services policies and procedures in order to provide proper assistance. PCPs may refer Members to the CHP Call Center using three-way conference calling. Also, Members may contact the CHP Call Center directly at any time.

Duties of CHP Call Center staff include, but are not limited to:

1. Participating in CHP marketing events to increase Medi-Cal enrollments.

2. Providing grievance assistance to all Members expressing a concern relative to services provided by CHP, or personnel, or affiliated providers; preparing reports of issues and requested resolutions; conducting investigations; re-marketing CHP services; and as authorized, resolving Member and provider problems.

3. Assisting Members in obtaining and understanding all information related to accessing health care services as referenced in the L. A. Care Member Handbook.

4. Assisting Two-Plan Model Medi-Cal beneficiaries with eligibility issues/problems in order to ensure their continued qualification for CHP benefits and services.

5. Providing information related to Two-Plan Model enrollment/disenrollment processes, role of Health Care Options (HCO) and referral telephone numbers, where to participate in an HCO presentation, and how to use the enrollment form.

6. Conducting Member education and providing additional information regarding the plan to potential disenrollees and transfers to other L.A. Care Plan Partners.

7. Facilitating Member requests to transfer to another Plan provider.

8. Providing assistance to pharmacy contractors to resolve pharmacy issues expeditiously and to ensure the timely provision of high quality services.

9. Processing mandatory and emergency Medi-Cal disenrollments, according to State disenrollment regulations.

The CHP Call Center provides assistance to Members who are experiencing problems

MEMBER SERVICES (continued)

with maintaining continued Medi-Cal eligibility. If a Member requires assistance with a Medi-Cal problem/issue, PCP staff should immediately contact the CHP Call Center at 1 (800) 475-5550 while the Member is still in the provider's clinic/office. A CHP Customer Services Representative will obtain from the Member, all pertinent information needed for appropriate follow-up and resolution of the eligibility problem.

MEMBER ELIGIBILITY

When a CHP Member presents for service, the PCP must verify the Member's eligibility before services are rendered. In addition to the CHP's Patient Management System (County sites only) and the State's Medi-Cal On-line Eligibility System, Medi-Cal Member eligibility may be confirmed by contacting L.A. Care or by utilizing CHP's: 1) PCP's Monthly Eligibility Roster, 2) Dial-In Eligibility Verification System, or 3) CHP Customer Service Center.

Primary Care Providers Monthly Eligibility Reports

CHP provides monthly Medi-Cal eligibility reports to each Provider Group. The reports delineate Medi-Cal Members for which capitation was issued and should be used to confirm current month's eligibility to Plan services.

A monthly Temporary Employees' Listing is provided confirming Temporary County Employees eligibility for the current month.

Dial-in Eligibility Verification System

The Dial-In Eligibility Verification System is a component of the Plan's Patient Management System (PMS), an information and communication system which is updated daily and is designed to receive, record, and retrieve a variety of information necessary to the administration of a health maintenance organization. The PMS is the repository for Member eligibility, patient encounters, claims, and other medical and financial information.

The Dial-in Eligibility Verification System provides for electronic verification of Member eligibility utilizing a personal computer and modem. Contract providers who elect to use this method will be provided a unique telephone number for accessing the PMS and may use their choice of communications software to perform eligibility inquiries only. CHP's Information Systems section should be contacted at (213) 240-8186 to activate Access to the Dial-In Eligibility Verification System.

PMS Training: Assistance will be provided in setting up personal computers to dial into the PMS system.

MEMBER ELIGIBILITY (continued)

CHP Customer Service Center Verification

Verification of a Member's CHP enrollment/eligibility and assigned PCP may be obtained by calling the CHP Call Center at 1 (800) 475-5550.

L.A. Care Verification

Medi-Cal Member enrollment/eligibility and primary care provider information may also be obtained by contacting L.A. Care at 1 (888) 452-2273.

Medi-Cal On-Line Eligibility/Automated Eligibility Verification Systems

Verification of Plan eligibility can be completed at the PCP level utilizing the Medi-Cal Beneficiary Identification Card, On-line Eligibility System (OES), and a Point-of-Service device. The On-Line Eligibility System allows access to State files for verifying Plan enrollment. PCPs are to continue to follow existing Medi-Cal procedures with regard to utilizing the State's OES. In addition to OES, PCPs can access the State's Automated Eligibility Verification System. A personal identification number (PIN) is required.

Each Member is instructed at enrollment to present proof of eligibility to the PCP and specialty care physician at each office visit, as Plan membership may change. Consequently, an individual may be eligible one month and ineligible the next. Providers are responsible for attempting to verify eligibility at each office visit through methods referenced above prior to providing services.

CHP Members may present with the following forms of identification:

1. L.A. Care/CHP identification card - This card is produced and issued by CHP and provides the Member's name, date of birth and social security number. **HOWEVER, THIS CARD ALONE DOES NOT CONSTITUTE PROOF OF ELIGIBILITY**. It must be supplemented with verification of enrollment through either the provider's monthly eligibility report, the Dial-in Eligibility System, CHP Customer Service Center, or Medi-Cal On-line Eligibility System.

2. Medi-Cal Beneficiary Identification Card - This card is used with the Point-of-Service Device and will provide Member enrollment/eligibility information. The Member's 14-digit Medi-Cal State Aid number can also be acquired utilizing the Point-of-Service device.

MEMBER ENROLLMENT AND ASSIGNMENT

The State Department of Health Services (SDHS) conducts the process of Member enrollment and disenrollment into and out of L.A. Care. This is accomplished through SDHS contracted Health Care Options (HCO) program. The current contractor is Maximus. To contact HCO, call 1(800) 430-4263.

L.A. Care processes CHP Plan enrollment information and sends it to CHP. It also transfers Members from one Plan Partner to another, when requested by a Member or when otherwise appropriate.

How Members Are Enrolled Into CHP/L.A. Care

HCO enrolls Medi-Cal beneficiaries into L.A. Care (Local Initiative) or Health Net (Commercial Plan) of the Two-Plan Model. Individuals in mandatory aid codes who do not select L.A. Care or Health Net will be defaulted into one of them using a special assignment algorithm. Beneficiaries may disenroll from L.A. Care or Health Net and enroll in the other Plan.

How Members Are Disenrolled From CHP/L.A. Care

Mandatory Disenrollment: A Member may be disenrolled because of a loss of Medi-Cal eligibility, or relocating outside L.A. County, or as a result of change of aid code.

Provider Group/PCP Initiated Member Transfer (See Exhibit A)

All Provider Group/PCP initiated Member transfers must be approved by the CHP Chief Medical Officer. A Member's medical condition; the amount, variety, or cost of covered services; and demographic and cultural characteristics are not acceptable grounds for a provider to seek the transfer of a Member. CHP Administration will determine if the grounds for a provider seeking to transfer a Member is acceptable.

Enrollment Aid Codes

The managed care mandatory, voluntary and ineligible Medi-Cal aid codes, as determined by SDHS, are as follows:

Mandatory Enrollment Aid Codes

Public Assistance, Family (Aid to Families with Dependent Children/AFDC) - Codes 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 7A, 7X, 30, 32, 33, 35, 38, 39, 54, 59, and 5X
Medically Needy, Family (AFDC), No Share of Cost - Code 34
Medically Indigent Children - Code 8P, 8R, 72 and 82
Refugee/New Entrant - Codes 0A, 01, 02 and 08

MEMBER ENROLLMENT AND ASSIGNMENT (continued)

Voluntary Enrollment Aid Codes

Public Assistance, Aged - Codes 10, 16, and 18
Public Assistance, Blind/Disabled - Codes 6A, 6C, 20, 26, 28, 36, 60, 66, and 68
Public Assistance, Foster Care - Codes 4F, 4G, 40, 42, and 5K
Medically Needy, Aged - Codes 1A and 14
Medically Needy, Blind/Disabled - Codes 24 and 64
Medically Indigent Adult - Code 86
Medically Indigent Children - Codes 03, 04, 4A, 4C, 4K, 5K, 45, and 7J

Ineligible Aid Codes

All other codes are not eligible (e.g., long-term care; share of cost; IRCA/OBRA)

Selection and Autoassignment

Selection

To facilitate enrollment procedures and thoughtful consumer selection of a Health Plan, HCO conducts local enrollment information meetings, distributes written information about the Two-Plan Model and distributes enrollment materials. HCO stresses beneficiary selection of either L.A. Care (the Local Initiative) or Health Net (the Commercial Plan) and selection of a PCP.

Selection of a PCP through L.A. Care will result in a corresponding selection of an L.A. Care Plan Partner. The provider identification number includes a Plan Partner identifier.

Medi-Cal beneficiaries in mandatory aid codes will be provided an enrollment package by HCO. The enrollment package will contain information regarding L.A. Care and Health Net Health Plans as well as provider directories for each. The enrollment package will also contain a toll-free telephone number for HCO and a schedule of local informational meetings. Medi-Cal beneficiaries who receive an enrollment package have approximately 30 days to select L.A. Care or Health Net, a PCP and a Plan Partner. If a selection is not made, the beneficiary will be defaulted to L.A. Care or Health Net.

Two follow-up letters will be sent to the beneficiary by HCO. The first is a letter of intent to assign. It is sent 10 days after the enrollment package and encourages the Medi-Cal beneficiary to return complete enrollment forms. Beneficiaries who do not complete

MEMBER ENROLLMENT AND ASSIGNMENT (continued)

an enrollment form within 30 days are sent an assignment letter, which notifies the beneficiary of assignment to L.A. Care or Health Net. The letter also states the new Member's option of changing this assignment.

Autoassignment to Plan Partners and Primary Care Physicians

L.A. Care will make an automated assignment of new Members to a PCP and a Plan Partner if they do not make a selection. This will be accomplished within 7 days of L.A. Care's receipt of enrollment information.

The algorithm used for the auto-assignment accounts for the Member's area of residence, the Member's primary language, the capacity of each Plan Partner, preference to traditional and safety net PCPs in each Plan Partner's provider network, and other variables.

Notification of Enrollment and Assignment

HCO provides information on enrollment to L.A. Care. L.A. Care will notify Plan Partners of new Members.

Within the first 7 days of enrollment, CHP will furnish each new Member with materials which include an L.A. Care Member Handbook/Combined Evidence of Coverage and Disclosure, Member identification card, 24 hour emergency numbers, CHP Provider and Pharmacy Directories, and other information regarding the CHP and the Member's PCP.

Notice Regarding Change in Covered Services

Members are to be informed of changes in services, such as PCP location and office hours, 60 days prior to the actual date of change (or 14 days in an emergency).

Member Rights and Responsibilities

Member Rights and Responsibilities can be found in the Member Handbook and the L.A. Care poster must also be displayed at each PCP location.

MEMBER ENROLLMENT AND ASSIGNMENT (continued)

Member Identification Card

The CHP Member identification card identifies individuals as Members of L.A. Care and CHP. CHP Member identification cards are produced and issued by CHP. The card maintains the specifications of CHP's standard Member identification cards, but have the L.A. Care logo, color, and a common top front-side layout.

Additionally, the CHP Member identification card contains an L.A. Care membership number. This number is issued by L.A. Care and is sent to CHP. CHP PCPs are to use this identification number to identify L.A. Care Members.

MEMBER GRIEVANCES AND APPEALS

1. **Definitions**:

   Appeal is a written or verbal request from a Member or provider for reconsideration of a decision by a health plan with a goal of finding a mutually acceptable solution or to resolve a disputed question of fact. Examples of actions which may be appealed may include, but are not limited to the following:

   - The denial or limited authorization of a requested service, including the type or level of service.
   - The reduction, suspension, or termination of a previously authorized service;
   - The denial, in whole or in part, of payment for a service; or
   - The failure to furnish or arrange for a service or provide payment for a service in a timely manner.

   California Code of Regulations Title 28 is the health plan code of regulations that is enforced by the California Department of Managed Health Care.

   CHP/OMC Grievance Coordinator is the designated staff responsible for the receipt, logging, tracking and distribution of grievances. The Coordinator also investigates administrative grievances and obtains input from involved parties.

   CHP/OMC Clinical Grievance Coordinator is the designated Medical Administration staff person responsible for investigating the clinical grievances and obtaining input from involved parties.

   DMHC (The Department of Managed Health Care) regulates and licenses Health Maintenance Organizations (HMOs). The Department is responsible for ensuring

MEMBER GRIEVANCES AND APPEALS (continued)

Health Plan compliance with the Knox-Keene Health Care Service Plan Act of 1975 including a patient complaint process.

Grievance is a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for consideration or appeal made by a Member or the Member's representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance. A grievance is resolved and response provided to Member or representative within 30 calendar days of receipt.

Grievance/Appeal Acknowledgement Letter is sent to the Member as an acknowledgement of the grievance/appeal receipt by the Plan.

Independent Medical Review is another appeal process that a Member can use when:

Community Health Plan made a decision that a health care service is not medically necessary, and the Member may believe that all or part of that health care service has been wrongly denied, changed or delayed. This is known as a disputed healthcare service.

Independent Medical Review For Experimental and Investigational Therapies is a Member's appeal option to the Plan when a medical service, drug or equipment is denied because it is experimental or investigational in nature.

Integrated Physician Association (IPA)/Medical Group (MG) is a Community Health Plan contracted provider who may render primary care, specialty care, hospital, emergency, urgent care, and/or behavioral health services to the Member.

Member Grievance Form is a form approved by DMHC and used to capture all pertinent information regarding a grievance. Forms will be available at all CHP provider sites, Provider Group offices, and CHP Member Services.

Member's Representative is a spouse, person(s) appointed by the Member via written statement of representative, health care proxy, trustee named in a durable power of attorney, court appointed guardian.

Non-Urgent Appeal is a formal appeal process whereby a Member or provider exercises his or her right to contest and request a reversal of a decision to deny or partially deny a benefit, service or claim. A final disposition on a non-urgent appeal must be made and communicated back to the Member and provider within 30 calendar days.

MEMBER GRIEVANCES AND APPEALS (continued)

***Provider Group Grievance* Coordinator** is the designated staff person responsible for the receipt, logging, tracking and distribution of grievances.

Quality Improvement/Quality Management is CHP's system for the tracking and trending of aggregated data to be analyzed in order to identify recurrent or systemic issues and to correct them. Identified issues are forwarded to CHP's Quality Improvement Committee for intervention.

Request for Assistance (RFA) is a Member's request to DMHC to intervene and provide assistance in bringing an unresolved grievance to a satisfactory resolution.

Urgent Clinical Grievance is an urgent grievance/appeal for cases involving an imminent and serious threat to the health of the Member, including, but not limited to, potential loss of life, limb or major body function.

2. **General Overview:**

The administrative and medically related grievance process is designed to provide a friendly mechanism through which a Member can register dissatisfaction with services and/or medical care received; and to provide a process for incorporating Member grievance information into the CHP Quality Management Program.

The CHP Member may submit a grievance relative to the perceived and/or demonstrated quality of service and/or care provided by the Plan, physicians, other health care professionals and staff, and/or entities. The Member may directly contact CHP or his/her CHP provider to submit a grievance. This communication may be by telephone, on line (**www.ladhs.org/chp**), in person, or in writing. **As required by Title 28, Article 8, Section 1300.68(b)(7) grievance forms and copies of both clinical and administrative grievance procedures shall be readily available at each CHP provider location.**

The Provider Group is not to turn away and/or re-direct to CHP's Member Service Center a Member requesting to submit a grievance at the time that the Member is in the provider's office or facility. If a Member states that she/he wants to submit a grievance, the Grievance Form is completed and processed following the Plan's Grievance procedures.

The Member shall receive an explanation of the grievance process and, upon request, assistance in writing a grievance. Information is provided regarding the CHP's appeal processes, and directions on how to initiate a request for assistance (RFA) from the Department of Managed Health Care (DMHC). Provider Group

MEMBER GRIEVANCES AND APPEALS (continued)

administrators will ensure compliance with the Plan's grievances procedures so that the Plan may avert MRMIB and DMHC regulatory sanctions for non-compliance with State grievance mandates.

Grievances are addressed by CHP and the provider. Provider Group staff and CHP administrative staff will work together to reach equitable resolutions to Members' grievances, appeals, and RFA from DMHC. CHP's network of providers, their respective staff and CHP administration will respond expeditiously to requests for information. The grievance resolution process is not delegated to CHP's Provider Groups, with the exception that CHP has delegated the grievance resolution process to its behavioral health services contract provider and HFP contractors (Universal Care, Inc. and L.A. Care Health Plan). CHP Administration Member Services Division will finalize and mail-out all Member acknowledgement and resolution letters.

A CHP Member grievance does not require a written grievance acknowledgement letter to a Member if all of the following criteria are met:

- Member grievance filed by telephone, fax, e-mail or CHP's website;
- Does not involve a coverage dispute;
- Does not involve disputed health care service involving medical necessity;
- Does not involve experimental or investigational treatment; and
- Is resolved by the close of the next business day.

Provider Groups, however, are still required to record these grievance proceedings on their monthly grievance logs and to report these to CHP.

Discrimination against a Member as a result of a Member filing a grievance is not practiced under any circumstances.

Once the Member has determined that he/she wants to submit a grievance, the proper grievance form must be submitted by the Provider Group to CHP/OMC Grievance Coordinator within twenty-four (24) hours. The urgent grievance information form must be submitted via secured fax the same day of receipt.

Members filing an urgent grievance must be informed immediately, in writing, of their right to notify the Department of Managed Health Care (DMHC) of the grievance. This information is also contained in the Grievance Acknowledgement Letter.

The grievance process starts from the moment the Member files the grievance. The CHP/OMC Grievance Coordinator sends a Grievance Acknowledgment letter to the Member within five (5) calendar days for non-urgent grievances and twenty-four

MEMBER GRIEVANCES AND APPEALS (continued)

hours for urgent grievances. Once the grievance process begins, the turn around time for non-urgent grievances is thirty (30) calendar days and three (3) calendar days for urgent grievances.

The CHP/OMC Grievance Coordinator distributes to the respective departments for investigation the completed grievance form with all available information. The CHP/OMC Grievance Coordinator can be contacted at 1 (800) 475-5550. Information can be faxed to (626) 299-7259.

Upon the grievance investigation completion, the Member will receive a resolution letter from the CHP/OMC Grievance Coordinator or the CHP/OMC Clinical Grievance Coordinator. For grievances involved in the delay, denial, or modification of health care services, the response must describe the criteria and clinical reason related to medical necessity and Member's right to an Independent Medical Review. If the decision to delay, deny or modify is based in whole or in part on a finding that the proposed health care services are not a covered benefit, the decision shall clearly specify the provision in the contract that exclude the coverage.

The Provider Group will ensure compliance with the Plan's grievance process so that the Plan may avert DMHC regulatory sanctions for non-compliance with State grievance mandates.

3. **Appeals to the Department of Managed Health Care (DMHC)**

DMHC is responsible for regulating health care service plans. If the Member has a grievance against the CHP, the Member should first telephone the CHP at (**1-800-475-5550**) and use the CHP grievance process before contacting DMHC.

Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to the Member.

If the Member needs help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved, or a grievance that has remained unresolved for more than 30 days, the Member may call DMHC for assistance.

4. **Independent Medical Review (IMR)**

The IMR is another appeal process that the Members may use if the Member believes a health care service should not have been denied, changed, or delayed by the Plan. The Member has up to six (6) months from the date of denial to file an IMR. The Member must first go through the CHP grievance process, before applying for an IMR. In an urgent situation, the Member may file for an IMR with DMHC within a shorter time period.

MEMBER GRIEVANCES AND APPEALS (continued)

There are no fees for an IMR. The Member has the right to provide information in support of the Member's request for an IMR. After the IMR application is submitted, a decision not to take part in the IMR process may cause the Member to forfeit certain legal rights to pursue legal action against CHP.

The IMR is filed with the DMHC and the Member will receive information on how to file an IMR with their denial letter. The Member may reach the DMHC toll-free at **1-888-HMO-2219** or **1-888-466-2219.**

When The Member Files An IMR

The Member must meet all of the three requirements to file an IMR:

A.
1) The Member's provider has recommended a health care service as medically necessary and it was denied; or
2) The Member received urgent care or *emergency* services that a provider determined was necessary and payment was denied; or
3) The Member has been seen by a network provider or a PCP for the diagnosis or treatment of the medical condition (even if the health care service was not recommended by a network provider).

B. The disputed health care service has been denied, changed, or delayed by CHP. Care based in whole or in part on a decision that the health care service is not medically necessary.

C. The Member has filed a grievance with CHP and the service is still denied, modified, delayed, or the grievance remains unresolved after 30 days.

The dispute will be submitted to a DMHC medical specialist if it is eligible for an IMR. The specialist will make an independent decision of whether or not the proposed treatment is likely to be more beneficial than any available standard therapy. The Member will receive a copy of the IMR decision from the DMHC. If it is decided that the service is medically necessary, CHP will provide the health care service.

If the Member's grievance requires an expedited review, the Member does not have to participate in CHP's grievance process for more than three (3) days.

If there is an imminent and serious threat to the Member's health as the information is reviewed by an independent medical review organization (within 24 hours of approval of request review) the DMHC may waive the requirement that the Member follow CHP's grievance process.

MEMBER GRIEVANCES AND APPEALS (continued)

5. Maintenance of Member Grievance and Appeals Records

Evidence of the investigation must be on file and in accordance with California Code of Regulations Title 28. This also may include development of a corrective action plan to ensure that the issue(s) does not recur.

All records related to Member grievances will be maintained for five (5) years after closing the active record. The following are record maintenance requirements:

Records may be stored in paper or electronic format.
Records that have been inactive for at least two (2) years may be stored at an alternate storage facility, but they must be retrievable within five (5) working days of a record request.

6. Mandatory Grievance Notice

Providers shall post the following notice in 12-point boldface type in a conspicuous place in all waiting areas:

"If you have a grievance against your **Community Health Plan**, you should first telephone your **Community Health Plan** at (**1-800-475-5550**) and use your **Community Health Plan's** grievance process before contacting the Department.

Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you.

If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your **Community Health Plan**, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance.

You may be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by **Community Health Plan** related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number (**1-888-HMO-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The Department's Internet Web Site **http://www.hmohelp.ca.gov** has complaint forms IMR application forms and instructions online."

MEMBER GRIEVANCES AND APPEALS (continued)

7. CHP Mandatory Reporting Requirements

Both the Provider Group and the CHP/OMC Grievance Coordinator shall maintain monthly grievance logs. Each Provider Group will submit a monthly grievance report to the CHP/OMC Grievance Coordinator by the 5th calendar day of the following month. These logs can be faxed to (626) 299-7259.

8. Types of Grievances:

CHP Member Services is responsible for processing and ensuring resolution of all grievances received through provider sites, Provider Group administrative office's after-hours answering service, CHP's Customer Services Center. If the grievance does not involve a clinical or quality of care issue, it is handled by the CHP Administrative Grievance Coordinator. If the grievance involves a clinical or quality of care issue, it is handled by the CHP Clinical Grievance Coordinator.

Investigation/Resolution

A grievance which suggests a quality of care issue is handled as a clinical issue. All issues of the grievance are investigated with input from appropriate Provider Group staff. Evidence of the investigation must be on file. This may include development of a corrective action plan to ensure that the issue(s) does not recur.

Grievances and appeals are resolved and written response is provided to the Member within 30 calendar days of receipt of the grievance. The CHP must approve the actions taken to resolve a grievance.

Administrative Grievances: It includes any dissatisfaction by the Member with the Plan's quality of service and is not clinical in nature. Examples of quality of service issues include:

Accessibility by telephone or other (of Plan)
After hours access/availability (of PCP)
Attitude/miscommunication/response time (of Plan)
Claims/billing/charge discrepancies
Communications/behavior/attitude of provider or staff
Cultural issues
Enrollment/assignment/disenrollment
Facility/environment/access/ADA issues
Identification Cards
Linguistic issues
Eligibility

MEMBER GRIEVANCES AND APPEALS (continued)

PCP access/availability-geographic, telephone, referral
Pharmacy/service/access
Prolonged delay in appointment (PCP)
Prolonged wait in Provider's Office
Provider not available
Specialty access/availability-geographic, telephone, referral
Transportation
Written materials/marketing

Note: A grievance involving a quality of care issue is handled as a Clinical Grievance.

Clinical Grievance: Examples are as follows:

Ancillary Care services/durable medical equipment
Benefit issue – not covered
Carved out services (Dental)
Delay in service or authorization (Timeliness of Care)
Denial of emergency room visit
Denial of service – with letter (appeal)
Refusal of care/prescription by provider
Refusal of referral (Specialist or Ancillary Care)
Treatment/diagnosis/inappropriate care

Urgent Cases

A clinical grievance may be urgent (**urgent grievance**) if it involves an imminent and serious threat to the health of a Member, including but not limited to:
severe pain,
the potential loss of life, limb, or major body function,
immediate and serious deterioration of Member's health.

A Member may request an urgent review or appeal under the following conditions:

- The Member has been issued a denial for service
- The Member is appealing a delayed, denied, deferred and/or modified decision (e.g.: UM decisions, a request to overturn the Provider Group's decision, etc.)
- The Member is scheduled for ongoing service(s) or admission to a hospital within seventy-two (72) hours.

MEMBER GRIEVANCES AND APPEALS (continued)

- An attending physician indicates in writing the patient's health will suffer adverse consequence from the denial.

Only professionally qualified personnel who have the qualifications to identify medically urgent grievances are able to affect the disposition of a clinical grievance or grievance appeal.

If the urgent grievance relates to a Member's appeal to the Plan for services denied, deferred and/or modified by the Provider Group, the Member may request an Independent Medical Review by DMHC. However, the Member must first go through the CHP grievance process before applying for an IMR. In special cases, the DMHC may not require the Member to follow the CHP grievance process before filing an IMR.

9. Grievance Appeals

The Member has the right to appeal a CHP grievance resolution. The Member should be instructed to contact CHP for a grievance appeal or to directly manifest his/her disagreement to DMHC. The appeal may be a non-urgent or urgent.

If the Member decides to appeal at the level of CHP, the Member must contact CHP within thirty (30) days from the date of the grievance resolution notification. For urgent appeals, the Member must notify CHP immediately upon receipt of the Plan's decision. The CHP/OMC Grievance Coordinator will log and date the appeal for tracking purposes. An acknowledgement letter will be sent to the Member within five (5) days for a non-urgent appeal and twenty-four (24) hours for an urgent appeal.

-- Independent Medical Review For Experimental and Investigational Therapies (IMR-EIT)

The Member may request an IMR-EIT through DMHC when a medical service, drug or equipment is denied because it is experimental or investigational in nature. Community Health Plan will notify the Member in writing that they request an IMR-EIT within five days of the decision to deny coverage. The Member has up to 6 months from the date of denial to file an IMR-EIT. The Member may provide information to the IMR-EIT panel. The IMR-EIT panel will give the Member a written decision within 30 days from when their request was received. If the Member's doctor thinks that the proposed therapy will be less effective if delayed, the decision will be made within 7 days of the request for an expedited review. In urgent cases the IMR-EIT panel will give the Member a decision within 3 business days from the time of the information is received.

MEMBER GRIEVANCES AND APPEALS (continued)

The Member may file an IMR-EIT if they meet the following requirements:

The Member has a very serious condition that is “life-threatening” or “debilitating” (for example, terminal cancer).

The Member’s doctor must certify that:
the standard treatments were not or will not be effective, or
the standard treatments were not medically appropriate, or
the proposed treatment will be the most effective.

The Member certifies in writing that:

a drug, device, procedure, or other therapy is likely to work better than the standard treatment

based on two medical and scientific documents, the recommended treatment is likely to work better than the standard treatment.

The Member has been denied a drug, equipment, procedure, or other therapy recommended or requested by your doctor.

The treatment would have been covered as a benefit, **CHP** has determined that it is *experimental and investigational*.

For more information or help with the IMR or IMR-EIT process or to request an application form, the Member can call **CHP**.

CHP PRIMARY CARE PROVIDERS' ROLES AND RESPONSIBILITIES - SECTION 4

CHP PRIMARY CARE PROVIDERS' ROLE

The Primary Care Provider (PCP) within the CHP network is responsible for coordinating all aspects of medical care, including referrals to specialty care physicians and other ancillary providers, all tests and procedures, and admissions.

Upon referral to other services, the PCP continues to provide Case Management services, is the gatekeeper within each managed care system and is responsible for supervising, coordinating and providing initial and follow-up care to Plan Members.

PCPs are responsible for:

- Providing appropriate medically necessary services;
- Ensuring access to care 24 hours a day in the most appropriate setting;
- Referring Members to specialists and ancillary services as necessary;
- Maintaining confidentiality of medical records;
- Providing preventive health services and health education services;
- Complying with CHP and L.A. Care QM & UM requirements and procedures;
- Ensuring medical records are accessible to CHP, L.A. Care, SDHS, DMHC, and any other entities for which L.A. Care requests access to records;
- Ensuring clinical continuity and coordination of care as well as access to referral services, including out-of-plan services and special programs and services (such as California Children Services); (Providers are to use MOU agreements to provide for coordination and continuity of care for special services and programs);
- Resolving Member grievances at the provider level through an established and documented grievance process;
- Complying with CHP and L.A. Care credentialing requirements;
- Ensuring adherence to all aspects of office and facility reviews, including but not limited to those listed below:
    - -- preventive services;
    - -- medical records standards;
    - -- facility safety and cleanliness;
    - -- emergency plans and procedures;
    - -- policies and procedures in place, current & functioning;
    - -- staff appropriately licensed, certified & trained;
    - -- Disabled accommodations that meet Americans with Disabilities Act standards;
    - -- pharmaceutical storage and dispensation;
    - -- infection control and biohazardous waste disposal;
    - -- laboratory and radiology services;
    - -- CHDP and other clinical requirements.

CHP PRIMARY CARE PROVIDERS' ROLE (continued)

- Abiding by the Knox-Keene Health Care Service Plan Act of 1975 which protects Members from receiving bills or statements of any kind, except for non-authorized services, non-covered services and/or co-payments. It is the PCP's responsibility to verify eligibility for services prior to rendering care.
- Adhering to the CHP Formulary (See Exhibit B) and Mandatory Generic Policy or contacting the Plan for use of non-formulary drugs (See Exhibit D for NonFormulary Drug Prior Authorization Request Form).
- Directing Members to Plan participating pharmacies.
- Complying with the Plan's emergency care procedures.
- Participating in and complying with CHP's Quality Assessment and Improvement Program and Utilization procedures, including initial credentialing and subsequent re-credentialing.
- Making arrangements with a covering PCP (preferably also Plan affiliated) who will be available to see Members when the PCP is not in the office, and ensuring that the covering PCP adheres to the Knox-Keene Act.
- Verifying a Member's eligibility for CHP services through the procedures outlined in this manual.
- Providing all covered medical services without discrimination based on gender, religion, sexual preference, national ethnic origin, age, preexisting conditions, or physical or mental disability.
- Complying with American Academy of Pediatrics (AAP) and CHP standards for the provision of services (Exhibit J, and Exhibit K).
- Maintaining a complete medical record for each Member, including emergency room and specialist treatment.
- Submitting valid inpatient, outpatient and long term care encounter data electronically to the CHP Managed Care Information System as outlined in Section 14 of this Manual, Data Exchange, Encounter Data Submission.

Provider Groups contracting with CHP must have at least one PCP who maintains staff privileges at one or more of the Plan's contract hospitals that are affiliated with the Provider Group.

Coordination of Medically Necessary Services

The PCP will serve as the medical case manager and gatekeeper. As such, the PCP is responsible for making referrals and coordinating necessary services.

Outpatient Referral

For patients requiring services beyond the scope of primary care, the PCP shall:

1) Authorize the referral or obtain authorization, when needed;
2) Refer the Member to the appropriate specialist or facility. The PCP, office staff, or Member may arrange the referral appointment;

CHP PRIMARY CARE PROVIDERS' ROLE (continued)

3) Note the referral in the Member's medical record and attach any authorization paperwork;
4) Discuss the case with the Member and the referral provider;
5) Receive reports and feedback from the referral provider regarding the consultation and treatment. (A written report must be sent back to the PCP by the referral provider or facility the Member was referred to.);
6) Discuss the results of the referral and any plan for further treatment, if needed, and care coordination with the Member.

Referrals are to be tracked by the PCP's office and the tickler file, log or computerized tracking. The tracking mechanism will include:

- Member name and identification number;
- diagnosis;
- date of authorization request;
- date of authorization;
- date of appointment; and
- date consult report received.

Hospital Inpatient Care

For hospital inpatient care, PCP responsibilities include Inpatient Concurrent Review and Discharge Planning.

Authorization Denial, Deferral, and/or Modification & Notification

A denial, deferral, and/or modification of a prior-authorization request may occur, therefore more information or recommendations or alternative care may be obtained during the authorization process.

A written notification of prior authorization request denial, deferral and/or modification will be sent to the Member and specialty physician (see Exhibit W).

Notification will occur:
1) within 1 working day of determination.
2) before the denial, deferral, and/or modification is implemented, and
3) when all of the conditions below exist:

- The request is made by a health care provider who has a formal arrangement with CHP or with a provider providing services to CHP Members.

The request is made by the provider through the formal prior- authorization procedures operated by CHP or its Provider Groups.

CHP PRIMARY CARE PROVIDERS' ROLE (continued)

- The service for which prior authorization is requested is a Medi-Cal covered service for which CHP or its Provider Groups have established a prior-authorization requirement.
- The prior-authorization decision is made at the highest level of responsibility within the delegated UM Program but prior to the point at which the Member must initiate the grievance procedure to reverse the determination.

The notice must include:

- A Member's right to file a grievance concerning the determination using the grievance process prescribed in the UM Program prior to or concurrent with the initiation of a request for a Fair Hearing.
- A Member's right to, and method for obtaining, a Fair Hearing to contest the denial, deferral or modification action.
- A Member's right to represent himself/herself at the Fair Hearing or to be represented by legal counsel or other spokesperson.
- The name and address of the entity making the determination and the State's toll-free telephone number for obtaining information on legal service organizations for representation.

MID-LEVEL MEDICAL PRACTITIONERS

Mid-level practitioners are nurse practitioners, physician assistants, and nurse midwives who provide primary care services. The use of mid-level practitioners is designed to increase Members' access to appropriate primary care and specialty medical services, maximize the patient's health and well-being, and promote cost-effective care. The delegation of specified medical procedures to mid-level practitioners does not relieve the supervising physician of ultimate responsibility for the welfare of the patient or actions of the mid-level practitioner.

Physicians may supervise up to four mid-level practitioners according to the following:

1. One physician to four nurse practitioners.
2. One physician to three midwives.
3. One physician to two physician assistants.
4. Four mid-level practitioners in any combination that does not include more than three nurse midwives or two physician assistants and maintain the full-time equivalence limits.

A single mid-level practitioner can potentially increase the supervising physician's capacity by 1,000 Members. However, when all practitioners are added, the physician cannot be responsible for more than 5,000 patients in total.

The mid-level practitioner may only provide those medical services that he/she is competent to perform and which are consistent with the practitioner's education, training and experience, the terms of which must be delineated in writing by the supervising physician. The stipulated scope of practice must be in full compliance with standards set forth by the Physician Assistant Examining Committee of the Medical Board of California, California Board of Nursing, the Nursing Practice Act, SDHS, DMHC, the California Code of Regulations, the California Business and Professions Code, and the requirements of any other applicable professional licensing body, law, and regulations.

A scope of practice agreement which is signed by the mid-level practitioner and the supervising physician as well as standardized procedures must be filed and maintained at the medical practice site. The scope of practice agreement must address the following elements:

1. Delegated responsibilities
2. Disciplinary policies
3. Method and frequency of physician supervision
4. Monitoring and evaluation of the mid-level practitioner
5. Chart review requirements

Term of the agreement/contract

MID-LEVEL MEDICAL PRACTITIONERS (continued)

The following elements must be contained within the standardized procedures for mid-level practitioners, and reflected in their written agreements as indicated above:

1. The supervisor or backup physician is to be available in person or through electronic means at all times when the mid-level practitioner is caring for patients.
2. The supervising physician is to consistently review tasks delegated to the mid-level practitioners for competency.
3. 10% of the medical record documentation by the mid-level practitioner is to be reviewed and countersigned by the supervising physician within 30 days of the date care was provided.
4. A physician assistant (PA) and his/her supervising physician shall establish written guidelines (signed by both parties) for the adequate supervision of the PA which shall include at least one of the following:

    a. Examination of the patient by a supervising physician the same day as care is given by the PA.

    b. Countersignature and dating of all medical records written by the PA within 30 days that care was given by the PA.

    c. The supervising physician will adopt protocols to govern the performance of a Physician Assistant for some or all tasks. The minimum content for a protocol governing diagnosis and management as referred to in this section shall include the presence or absence of symptoms, signs, and other data necessary to establish a diagnosis or assessment, any appropriate tests or studies, drugs recommended to the patient, and education to be provided to the patient.

    For protocols governing procedures, the protocol shall state the information to be provided to the patient, the nature of consent to be obtained from the patient, the preparation and technique of the procedure, and the follow-up care.

    Protocols shall be developed by the physician, adopted from or referenced to texts or other sources. Protocols shall be signed and dated by the supervising physician and the physician assistant.

    The supervising physician shall review, countersign, and date a minimum of a 10% sample of medical records of patients treated by the Physician Assistant functioning under these protocols within 30 days. The physician shall select for review those cases, which by diagnosis, problem, treatment, or procedure represent, in his or her judgment, the most significant risk to the patient.

SPECIALTY PROVIDERS' ROLE

PCPs may refer Plan patients, as medically appropriate, to CHP affiliated specialty care providers.

Specialty Care Provider's Responsibility

Specialists are responsible for:

a. Providing appropriate medically necessary services;
b. Ensuring access to 24 hour a day care in the most appropriate setting;
c. Maintaining confidentiality of medical records;
d. Compliance with CHP's and L.A. Care's QM and UM requirements and procedures, including Provider Credentialing for all affiliated providers;
e. Ensuring patient continuity of care by reporting back to primary care providers regarding referred Members;
f. Abiding by the Knox-Keene Health Care Service Plan Act of 1975, which protects Members from receiving bills or statements of any kind, except for non-authorized services, and/or non-covered services. It is the responsibility of the specialty provider as well as the Primary Care Provider to recognize non-covered services prior to rendering care, and to inform the patient that she/he may be personally liable for the unauthorized services;
g. Following approved guidelines for specialty care;
h. Using Plan affiliated hospitals;
i. Contacting the Primary Care Provider if another specialty care provider referral is needed for the patient's care;
j. Adhering to the CHP Formulary (Exhibit B) and the Mandatory Generic Policy for contacting the Plan for use of non-formulary drugs. [Non-Formulary Drug Prior Authorization Request Form (Exhibit D)];
k. Directing Members to Plan participating pharmacies; and
l. Providing all medical care services without discrimination based on religion, sexual preference, national ethnic origin, gender, age, preexisting conditions, or physical or mental disability.

HOSPITALS' ROLE

PCPs may refer Plan patients, as medically appropriate, to CHP affiliated hospitals.

Hospitals' Responsibility

Hospitals are responsible for providing:
a. Appropriate medically necessary services;
b. Ensuring 24-hour a day access to care;
Maintaining confidentiality of records;
Complying with CHP and L.A. Care QA and QI requirements and procedures;
e. Ensuring continuity of care by reporting back to primary care providers regarding referred Members.

Hospitals utilized by CHP providers must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

CHP continuously monitors the utilization of hospital services for appropriateness, usage of equipment, facilities, and service through the UM Programs.

CHP no longer reviews the hospital's QI activities but accepts their JCAHO review.

Inpatient quality functions may be further delegated to hospitals just as quality functions may be further delegated to physician Provider Groups.

CHP hospital agreements must include specifications and expectations that ongoing QM activities and functions ensure that the hospital conforms with accepted hospital practices within the community.

Generally, the concurrent and retrospective utilization review processes are not delegated to CHP hospitals but remain with the CHP or its Provider Groups.

Hospitals must cooperate with CHP and Provider Groups' QM Programs by allowing access to minutes or on site access when notified of an intended visit. Hospitals, ancillary providers, and vendors are required to comply with CHP and L.A. Care QA and QI requirements and procedures. They will be held accountable for their performance just as physicians are held accountable.

PERINATAL PROVIDERS

The CHP provides perinatal service to Members including post-natal well-baby care service to infants for the month of birth and the following month under the mother's membership. To enroll infants in Medi-Cal, contact an eligibility worker at Department of Public Social Services toll-free at 1-877-481-1044.

As needed, perinatal providers will be offered educational programs related to Comprehensive Perinatal Services Programs (CPSP). Perinatal providers are not required, as part of their credentialed status, to be CPSP certified. However, CPSP certification is highly recommended.

List of Clinicians Who Can be a Comprehensive Perinatal Practitioner

In accordance with Sections 10725, 14105, and 14124.5 of the California Welfare and Institutions Code and other sections, CPSP certification requires that the "Comprehensive Perinatal Practitioner" be any of the following:

1. A physician who is a:
   a. General practice physician
   b. Family practice physician
   c. Pediatrician
   d. Obstetrician/Gynecologist

2. A Certified Nurse Midwife as defined in the California Code of Regulations, Title 22, Section 51170.2.

3. A Registered Nurse who is licensed as such by the Board of Registered Nursing and who has one year of experience in the field of Maternal and Child Health.

4. A Nurse Practitioner as defined in Title 22, Section 51170.3.

5. A Physician's Assistant as defined in Title 22, Section 51170.1.

6. A Social Worker who holds:

   A minimum of a Master's Degree in social work or social welfare from an institution with a Social Work Degree program accredited by the Council of Social Work Education and who has one year of experience in the field of Maternal and Child Health, or

   A Master's Degree in Psychology or Marriage, Family & Child Counseling and has one year of experience in the field of Maternal & Child Health.

PERINATAL PROVIDERS (continued)

A Baccalaureate Degree in social work or social welfare from an institution with a Social Work Degree program accredited by the Council of Social Work Education and who has one year of experience in the field of Maternal and Child Health.

7. A Health Educator who holds:

   a. A Master's Degree (or higher) in Community or Public Health Education from a program accredited by the Council on Education for Public Health and who has one year of experience in the field of Maternal and Child Health, or

   b. A Baccalaureate Degree with a major in Community or Public Health Education and who has one year of experience in the field of Maternal and Child Health.

8. A Childbirth Educator who is:

   Licensed as a Registered Nurse by the Board of Registered Nursing and has one year of experience in a program which complies with the "Guidelines for Childbirth Education" (last published in 1981), incorporated by reference in its entirety and available from the American College of Obstetricians and Gynecologist, 600 Maryland Avenue, South West, Suite 300 East, Washington, D.C. 20024-2588;

   A Certified Childbirth Educator who has completed a training program and is currently certified to teach that method of childbirth education by the American Society for Psychoprophylaxis in Obstetrics, or Bradley, or the International Childbirth Education Association.

9. A Dietitian who is registered, or is eligible to be registered by the Commission on Dietetic Registration, the credentialing agency of the American Dietetic Association, with one year of experience in the field of perinatal nutrition.

10. A Comprehensive Perinatal Health Worker who:

    Is at least 18 years of age, is a high school graduate or equivalent, and has at least one year of full-time paid practical experience in providing perinatal care;

    Provides services in a clinic that is either licensed or exempted from licensure

PERINATAL PROVIDERS (continued)

under Section 1200 et seq. and 1250 et seq. of the Health and Safety Code, under the direct supervision of a comprehensive perinatal practitioner as defined in Title 22, Section 51179.7(a).

11. A Licensed Vocational Nurse who is licensed under Section 2516 of the Business and Professions Code and who has one year of experience in the field of Maternal and Child Health.

REQUIREMENTS FOR 120-DAY INITIAL HEALTH ASSESSMENT (IHA)

Community Health Plan Provider Groups are required to provide an IHA to each new CHP enrollee within 120 days of enrollment.

To meet the IHA requirements, CHP providers must:

Schedule and Provide an IHA to each new enrollee within 120 days of enrollment

or

Obtain new enrollee's medical record that contains documentation of prior IHA within 12 months prior to enrollment

or

Document two (2) attempts have been made to schedule a new enrollee for an IHA

An IHA documentation must include:

- A complete age appropriate comprehensive history and physical examination
- An age appropriate Individual Health Education Behavioral Assessment (IHEBA*) and that the IHEBA risk-reduction plan was reviewed with Members. (Note: IHEBA is a requirement for all Medi-Cal Managed Care Members only).
- A core set of age appropriate, gender-specific preventive services
- Documented evidence of any follow-up necessary as a result of the IHA and the diagnosis and plans for treatment of any disease
- For Members who are pregnant upon enrollment, or who are discovered to be pregnant prior to an IHA has been performed
  - The pregnancy must be noted and the comprehensive initial risk assessment must be completed or
  - A referral made for the initiation of pregnancy-related services, including the required risk assessment
- Health education and anticipatory guidance

The Providers must provide outreach to new Members regarding the need for an IHA, and follow their own policy on broken appointments and follow-up.

The IHA of new enrollees must be reported to CHP through self-report by the providers on a monthly and/or quarterly basis. CHP/QM nurses will monitor the providers' compliance with the IHA requirements through ongoing monthly and/or quarterly monitoring.

CASE COORDINATION

Case coordination includes all clinical aspects of care as well as record keeping and communication. A list of elements should be included.

Health Education Assessment

The Member must complete an assessment of his/her health behaviors and health education needs in conjunction with the IHA.

The PCP or allied health professional is responsible for reviewing the Member's individual health education behavioral assessment results and review of this assessment should take place in the examination room.

The completed assessment form and results are to be maintained in the Member's medical record.

ADVANCE DIRECTIVES

An Advance Directive is a written instruction, recognized under State law, relating to the provision of health care when an individual becomes incapacitated.

CHP Member Services will provide each new adult Member (age 18 and above) with a copy of the Advance Directives guidelines. Additionally, Primary Care Sites shall develop a system to ensure that Advance Directives' information is available to Plan Members upon request.

Non-CHP Advance Directives' guidelines shall be available for inspection to verify compliance with State regulations upon requests of Plan's Chief Medical Officer or designee.

REPORT OF POTENTIAL MEDICAL RISK MANAGEMENT INCIDENCE (EVENT NOTIFICATION)

CHP providers are responsible for reporting an adverse event, such as a therapeutic mishap occurs, Member or relative dissatisfied with treatment or results of treatment, unexpected death of a Plan Member, which may result in a claim or law suit against the Plan. The adverse event must be reported immediately by telephone to the Plan Medical Risk Management at (626) 299-5577 then complete the Event Notification Form, HS-10 (Exhibit E).

In addition to informing the Plan Medical Risk Management regarding the adverse event, DHS facilities should also follow their facility's own Risk Management procedures for reporting incidence.

CHP provider must send the original Event Notification Report in an envelope marked "CONFIDENTIAL", within 24 hours, to Community Health Plan, Medical Risk Management, 1000 S. Fremont Ave, Building A-9, E. 2nd Floor, Unit 4, Alhambra, CA 91803-8859. Events should be reported even if only partial statements of fact can be made. DO NOT MAKE PHOTOCOPIES OF THE REPORT.

CHP providers should treat the Event Notification Reports as privileged, confidential communications between the Plan, DHS CHP sites, non-County Subcontractor CHP sites, and the County's legal counsel in the area of risk management and medical malpractice.

DELEGATION OF CLINICAL/MEDICAL FUNCTIONS

CHP delegates the following clinical/medical functions to the participating Provider Groups:

- Credentialing
- Health Education/Cultural and Linguistics
- Quality Improvement
- Utilization Management*

The attached "Division of Responsibility Matrix for Delegated Functions" for each functional area further delineates the Plan's delegated functional categories and the Plan's retained functional categories.

To be approved by the Plan for delegation of the specified functions, participating Provider Groups must comply with the Plan's delegation criteria as follows:

DELEGATION OF CLINICAL/MEDICAL FUNCTIONS (continued)

- The function(s) must be in compliance with the Plan's program description, policies and procedures, applicable State and federal regulations and NCQA standards.

- The function(s) must pass the Plan's due diligence review prior to delegation and annually thereafter. In addition to the due diligence review, the Plan may require a periodic activity report from participating Provider Groups.

- If the participating Provider Group continues to meet the Plan's delegation standards, the delegation status is retained. If the participating Provider Group fails to meet the delegation standards, the Plan's Medical Administration staff will assist the Provider Group to develop a plan of action and reassess the Provider Group within 3-6 months after the corrective action plan has been approved. In the event the Provider Group continues to have significant deficiencies after a follow-up review. The case will be presented to the Plan Quality Improvement Committee for review and recommendations. Recommendations may include withdrawal of the delegation status.

* Delegation of Utilization Management responsibilities is applicable only to full risk Provider Groups and DHS facilities.

DIVISION OF RESPONSIBILITY MATRIX FOR DELEGATED FUNCTIONS (PRIMARY AND FULL RISK CONTRACTS) CREDENTIALING

Credentialing Category	Responsible Entity		
	CHP	Provider Group	DHS Facility
Credentialing Policies	X		
Credentialing Procedures		X	X
Credentialing Committee	X 1	X 2	X 2
Primary Source of Verification		X	X
Application and Attestation		X	X
Initial Sanction Information		X	X
Initial Credentialing Site Visits (n/a for specialists)	X		
Recredentialing Primary Source Verification		X	X
Recredentialing Sanction Information		X	X
Performance Monitoring (n/a for specialists)	X 1	X 2	X 2
Recredentialing Site Visits (n/a for specialists)	X		
Practitioner Appeal Rights	X 1	X 2	X 2
Assessment of Organizational Providers		X	X
Approval of New Provider and Site	X 1	X 2	X 2
Termination or suspension of provider	X 1	X 2	X 2

1 - At Plan Level
2 - At Provider Group/DHS Facility Level

Periodicity of Activity performance: prior to delegation and annually
Reporting schedule to the Plan: quarterly

DIVISION OF RESPONSIBILITY MATRIX FOR DELEGATED FUNCTIONS (PRIMARY AND FULL RISK CONTRACTS) HEALTH EDUCATION/CULTURAL AND LINGUISTIC SERVICES

Health Education/Cultural and Linguistics Category	Responsible Entity		
	CHP	Provider Group	DHS Facility
Review of Health Education Materials (where developed)	X 1	X 2	X 2
Oversight of Health Education Materials Review	X		
SDHS Mandated Health Education Print Materials	X		
Establishment of Health Education Standards	X		
Health Education Referrals		X	X
Individual Health Education/Counseling		X	X
Health Education Classes		X	X
Quarterly Health News	X		
Health Promotion to Members	X 1	X 2	X 2
Annual Health Education Work Plan	X 1	X 2	X 2
Annual Evaluation of Health Education	X 1	X 2	X 2
Cultural and Linguistic Policies	X		
Cultural and Linguistics Procedures		X	X
Translation of SDHS Mandated Health Education Materials	X		
Interpreter Services (at provider site)		X	X
Interpreter Services (at pharmacies)	X		
Interpreter Services for CHP 24-Hour toll-free Number	X		

1 - At Plan Level
2 - At Provider Group/DHS Facility Level

Periodicity of Activity performance: prior to delegation and annually
Reporting schedule to the Plan: quarterly

DIVISION OF RESPONSIBILITY MATRIX FOR DELEGATED FUNCTIONS (PRIMARY AND FULL RISK CONTRACTS) QUALITY IMPROVEMENT (QI)

Quality Improvement Category	Responsible Entity		
	CHP	Provider Group	DHS Facility
QI Program Description	X 1	X 2	X 2
Annual QI Work Plan	X 1	X 2	X 2
Annual Evaluation of QI Plan	X 1	X 2	X 2
QI Committee	X 1	X 2	X 2
Governing Body	X 1	X 2	X 2
Accessibility of Services: Establish Standards for Clinic Appointments, Emergency Care & After-Hour Services Monitoring Accessibility of Care	 X X		
Annual Assessment of Member Satisfaction	X		
After-Hour Coverage		X	X
Oversight of After-Hour Coverage	X		
Clinical Practice Guidelines	X 1	X 2	X 2
Monitor and Evaluate Continuity and Coordination of Care	X	X 2	X 2
Clinical Measurement Activities	X 1	X 2	X 2
Facility Site Review	X		
Peer Review (where initiated)	X 1	X 2	X 2
Clinical Grievances Investigation (where initiated) Approval of Resolution Letters	X 1 X	X 2	X 2
Preventive Services Guidelines	X		
Medical Record Documentation Standards & Confidentiality Policies	X		
Medical Record Confidentiality Procedures		X	X

1 - At Plan Level
2 - At Provider Group/DHS Facility Level

Periodicity of Activity Performance: prior to delegation and annually
Reporting schedule to the Plan: quarterly

DIVISION OF RESPONSIBILITY MATRIX FOR DELEGATED FUNCTIONS (PRIMARY AND FULL RISK CONTRACTS) UTILIZATION MANAGEMENT (UM)

Utilization Management Category	Responsible Entity		
	CHP	Provider Group	DHS Facility
UM Program Description	X 1	X 2	X 2
Annual UM Work Plan	X 1	X 2	X 2
Annual UM Evaluation	X 1	X 2	X 2
UM Committee	X 1	X 2	X 2
Determine Utilization Criteria for UM Decisions	X		
Establish Time Line for UM Decision	X		
UM Policies	X		
UM Procedures		X	X
Review/Determination of Authorization Requests (In Services Areas)		X	X
Review/Determination of Authorization Requests (Out of Services Areas)	X		
Prospective Review (In Services Areas)		X	X
Prospective Review (Out of Services Areas)	X		
Concurrent Review (In Services Areas)		X	X
Concurrent Review (Out of Services Areas)	X		
Inpatient Review - Discharge Planning (In Services Area)		X	X
Inpatient Review - Discharge Planning (Out of Services Areas)	X		
Case Management (In Services Areas)		X	X
Case Management (Out of Services Areas)	X		
Claims Review	X	X (with delegated claims review)	
First Level Appeal	X		

DIVISION OF RESPONSIBILITY MATRIX FOR DELEGATED FUNCTIONS (PRIMARY AND FULL RISK CONTRACTS) UTILIZATION MANAGEMENT (UM) (continued)

Utilization Management Category (continued)	Responsible Entity		
	CHP	Provider Group	DHS Facility
Second Medical Opinion		X	X
UM Satisfaction Survey (Members and Providers)	X		
Development and Maintenance of Drug Formulary	X		
Approval of Non-Formulary Drugs	X		
Pharmacy and Therapeutics Committee	X		
Utilization Management Reports		X	X
Coordination of Services Between Primary Care and Linked/Carved Out Services		X	X
Monitor and Evaluation of Linked and Carved Out Programs MOUs	X		

1- At Plan Level
2- At Provider Group/DHS Facility Level

Periodicity of Activity performance: prior to delegation and annually
Reporting schedule to the Plan: quarterly

ACCESS STANDARDS - SECTION 5

CHP primary care sites must ensure that Members have access to providers according to the standards set forth below.

Routine Availability and Appointments

Access	CHP Standard
Availability of Primary Care Physician	• 24-hours per day/ seven days per week. • Adequate primary care capacity to serve the Members with travel time and distance standards of 10 miles travel distance or 30 minutes travel time from residence.
Appointments for Urgent Primary Care	• A Primary Care Physician is expected to schedule an appointment within 24 hours, triage and give same day services for patients determined to need urgent office based care.
Appointments for Routine Primary Care	• A Primary Care Physician is expected to schedule appointment as follows: - Physical exam/preventive services (routine) – 4 work weeks maximum for appointment - Routine ambulatory visit -- 10 working days maximum for appointment
Appointments for Routine Physician Ambulatory Consultation & Specialty Referral*	• The specialist physician is expected to schedule an appointment for a non-urgent, properly authorized referral within 21 calendar days. Separate standards will be established in cases of follow-up for patients subsequent for recent hospitalization. Professional judgment and community standards will be expected to drive appointment decisions. • Travel time or distance standard is 30 minutes or 15 miles from residence.
Appointments for Routine Prenatal Care	• Initial appointments must be available within one week. The obstetrician will establish a regular schedule of prenatal visits in accordance with standards adopted by L.A. Care.
Appointment Making Systems	• Providers should use an efficient and effective written or computerized appointment making system, which includes following up on broken appointments.

* Routine referrals, such as eye exams for diabetics, can be scheduled 6 or more months in advance.

ACCESS STANDARDS (continued)

Routine Availability and Appointments (continued)

Appointments for Sensitive Services	• Sensitive services must be made available to Members within two days of appointment request. Sensitive services mean services related to: - Sexual Assault - Drug or alcohol abuse - Pregnancy - Family Planning - Sexually Transmitted Diseases • These services will be provided under the following conditions: - Without necessity of pre-authorization, referral, or parental consent for minors 12 years of age and older - Confidentially, in a manner that respects the privacy and dignity of the individual.
120 Day Initial Health Assessment (IHA)	• Each newly enrolled Member will be provided with access to and encouragement to obtain an IHA to be conducted by his or her primary care physician, including a complete history and physical exam, within 120 days of enrollment. The presence of risk factors in a Member may affect the type and frequency intervals of ongoing assessments.

After Hours, Urgent, and Emergency Services

Access	CHP Standard
After hours, urgent, and emergency.	• 24-hour, 7 days per week basis. • Same day urgent care appointment.

Waiting Times for Scheduled Appointments

Access	CHP Standard
Waiting times for scheduled appointments for Primary Care	• The standard waiting times for scheduled appointments with Primary Care Physicians must be 30 minutes or less.
Waiting times for scheduled appointments for Specialty Care	• The probable waiting times for scheduled appointments with referral specialist care physicians must be 30 minutes or less.

ACCESS STANDARDS (continued)

Telephone Access

Physicians, or office staff, must return any non-emergency phone calls from Members within 24 hours of the Member's call. (Telephone consultation is not considered appropriate when the Primary Care Physician has not previously seen the patient.) Urgent and emergent calls are to be handled by the physician immediately.

The CHP physician on-call system is available 24-hours a day, 7 days a week by calling 1(800) 832-6334.

Telephone Waiting Time

Length of time for staff to answer the phone (includes period of time call placed on hold) is 0-60 seconds.

Language Interpretation Services

CHP requires that a Member be served in the language in which the Member is the most comfortable. Providers should refer to the Cultural and Linguistics Services Section (Section 11) of this Manual for further information.

Services for Members with Disabilities

CHP primary care sites and their providers are to comply with all provisions of the Americans with Disabilities Act.

COVERED AND NONCOVERED SERVICES - SECTION 6

Covered Services are medically necessary services that CHP is responsible for providing, or arranging for the provision, and are covered benefits under the L.A. Care. Currently, all CHP Members have coverage for medically necessary:

Office visits
Inpatient hospital services
Emergency and urgent care services
Ancillary services - Pharmacy, Lab, and Radiology
Benefits listed in the Combined Evidence of Coverage Disclosures (i.e., Membership Guide)

For determination of financial responsibility for some specific health care services, contractors should refer to their CHP Medi-Cal Managed Care Program Services Agreement.

EXCLUSIONS AND LIMITATIONS

The following list highlights the specific exclusions, and limitations which are set forth in the service agreement between CHP and County of Los Angeles Provider Groups with regard to Medi-Cal beneficiaries:

1. All services not capitated to CHP are provided by Medi-Cal under fee-for-service or through the Short-Doyle Act.

2. Any services other than those provided by the PCP, except emergencies, provided without prior approval of the CHP, or services rendered by participating specialty care providers before pre-authorization by the Member's PCP.

3. Services which are part of a plan of treatment for a non-covered service, including services and supplies to treat medical conditions which are recognized by the organized medical community in the State of California to be direct and predictable consequences of such non-covered services; provided, however, that the health plan shall not exclude coverage for medically necessary services required to treat medical conditions that may arise but are not predictable in advance, such as unexpected complications of surgery.

4. Medical, surgical or other health care procedures and treatments which are experimental or investigational, as determined by CHP in accordance with accepted medical practice and Plan policy and procedures.

COVERED AND NONCOVERED SERVICES (continued)

5. Eating disorder programs, dietary control and/or surgery or other treatment of obesity, including, but not limited to food and food supplements, laboratory tests in association with weight reduction programs, vitamins, gastric bubble or other similar procedures.

6. Alcohol, drug, or other substance abuse or addiction - except inpatient detoxification medically necessary for complicated cases.

7. Ambulance services, unless medically necessary and authorized through the Member's primary care clinic or necessitated by an emergency.

8. Self-donation of blood (autologous blood) or donation by family Members, friends, etc.

9. Bloodless surgery.

10. Bone marrow transplants.

11. Treatment for disabilities connected to military service for which a Member is legally entitled to services through a Federal governmental agency, and which is reasonably accessible to the Member.

12. Infertility drugs, in-vitro fertilization and embryo transplantation, gamete introfallopian transfer (GIFT), and any costs associated with the collection, preparation or storage of sperm for artificial insemination (including donor fees).

13. Transsexual surgery.

14. Custodial or domiciliary service - Extended care, homemaker services, home delivery of meals or convalescent care not requiring skilled nursing.

15. Dental Services - General dental services including, without limitation, items or services in connection with care, treatment, filling, removal, replacement, artificial restoration of the teeth or structures directly supporting the teeth, treatment of dental abscess, or other oral conditions. General dental services are defined as those services required to diagnose or treat, by surgery or other method, diseases and lesions; and the correction of malposition of the human teeth, alveolar process, gums, jaws, or associated structures, including all necessary related procedures

COVERED AND NONCOVERED SERVICES (continued)

as well as the use of drugs, anesthetic agents, prosthetic appliances, and physical evaluation. Also, treatment for mandibular or maxillary prognathism, micrognathism or malocclusion inclusion temporomandibular joint (TMJ) dysfunction, surgical augmentation for orthodontics, or maxillary constriction, unless medically necessary.

16. Medical and hospital services and other costs of an organ donor or prospective donor.

17. Optional accessories to equipment or devices primarily for the comfort or convenience of the Member. Durable medical equipment is not covered when a household item will adequately serve the patient's medical needs.

18. A medication that is prescribed for an experimental or non-FDA approved indication, unless prescribed in a manner consistent with a treatment for a specific indication, as referenced in the “Drug Information for the Healthcare Professional” (published by the United States Pharmacopoeia Convention), or in the “American Hospital Formulary Service Drug Information Reference” (published by the American Society of Health System Pharmacists), or in another reference(s) which can reflect the community practice standard, including; a medication that is limited to an investigational use (by law); a maintenance drug that is prescribed in quantities in excess of a one hundred (100) calendar day supply; a medication that is not listed in the CHP’s Drug Formulary unless determined to be of sufficient medical necessity (untreatable with formulary medications with an FDA-approved indication) as approved by the CHP.

    When a prescription is written for an “off-label” (non FDA-approved) use of an FDA-approved formulary medication, it should be (1) prescribed by a participating physician for a life-threatening condition, or (2) prescribed by a participating physician for a chronic AND debilitating condition that is treatable only outside the scope of formulary agents (under FDA guidelines). The proposed “off-label” use must be recognized as a treatment by the American Medical Association, or the United States Pharmacopoeia Convention (Dispensing Information, Volume One), or supported by two (2) articles from major peer-reviewed medical journals that have uncontradicted data that supports the proposed use as “safe and effective”. A Member should be directed to either a Los Angeles County Department of Health Services pharmacy or a CHP contract pharmacy when eligible prescription drugs are necessary.

COVERED AND NONCOVERED SERVICES (continued)

19. Private hospital rooms and/or private duty nursing unless determined to be medically necessary by the PCP.

20. Personal comfort items such as television, telephone or other articles not for the specific treatment of illness or injury.

21. Visual coverage is limited to therapeutic material rather than cosmetic material. Cosmetic is considered blended, oversized or photo chromic lenses, tinted lenses except Pink #1 or Pink #2, bifocals without lines or double segmented bifocals, progressive multi focal lenses, the coating or laminating of a lens or lenses, polycarbonate/high index plastic lenses, prism glasses or designer frames costing more than Plan allowance, Contact lenses (except post cataract extraction, anisometropia or when facial pathology or deformity precludes the use of eyeglasses).

    Replacement of lost or broken lenses and/or frames is not covered.

    One pair of eyeglasses every two years unless medically authorized by the PCP.

22. Chiropractic services.

23. Acupuncture, acupressure, biofeedback.

24. Replacement hearing aid batteries are not covered. Initial hearing aid batteries supplied with the hearing aid are covered when supplied with a hearing aid that has been prior authorized.

25. Inpatient Tuberculosis Services - Services received in any County hospital for the treatment of tuberculosis without other medical complications.

26. Any services or supplies furnished by a non-eligible institution. If a Member requests services, other than emergency services, that are not provided or authorized by the Plan, the Member may have to pay for such services.

27. Intermediate Care Facility (ICF) Services - Services exceeding one full calendar month. Skilled nursing facility combined with intermediate care services will count toward the limitation.

COVERED AND NONCOVERED SERVICES (continued)

28. ICF Services for the Developmentally Disabled (ICF-DD), ICF Services for the Developmentally Disabled Habilitative (ICF-DDH) or Developmentally Disabled Nursing (ICF-DDN).

29. Treatment for any illness or injury when not attended by a licensed physician, surgeon, or health care professional.

30. Services that are primarily oriented toward treating a social, developmental or learning problem rather than a medical problem.

31. Prayer/Spiritual healing, except the services of a Christian Science Practitioner as defined in Title 22, Section 51312.

32. Services provided by State or federal hospitals.

33. Cosmetic surgery, except prosthetic devices or reconstructive surgery to restore and achieve symmetry for the patient incident to a medically necessary mastectomy or unless medically necessary for the correction of an anatomical functional deficit.

34. Recreational, educational, or sleep therapy and any related diagnostic testing except as provided as part of an otherwise covered inpatient hospitalization.

35. Respiratory home care for ventilator-dependent individuals.

36. Reversal of voluntary sterilization.

37. Subacute Care Services - Long term or maintenance level inpatient care including respiratory care, physical, occupational and speech therapy beyond one full calendar month from the first date of subacute treatment per disability.

38. Voluntary abortion after the 20th week of gestation or more unless the mother's life is in jeopardy.

39. Major organ transplants, except kidney and cornea transplants.

40. Chronic hemodialysis

COVERED AND NONCOVERED SERVICES (continued)

The Contractor is not responsible for the following additional services:

1. Tertiary services: complex burns, spinal cord rehabilitation, and head trauma requiring neurosurgery treatment.

2. Non-emergent services in any federal or State government hospital

3. Non-emergent services for the treatment of chronic, medically uncomplicated narcotism, or alcoholism

4. Inpatient treatment of tuberculosis unless authorized in writing by the CHP Chief Medical Officer

5. Services rendered to Plan Members who are institutionalized for more than one calendar month after the month of admission to a skilled nursing or an intermediate care facility.

6. Laboratory services provided under the serum alphafeto protein testing program administered by the Genetic Disease Branch of the HHS.

7. Local Education Agency assessment services provided pursuant to an Individual Education Plan or Individual Service Plan.

8. Services provided under the California Children Services

9. The facility or per diem charge component of Covered Services rendered to Plan Members who are:

   a) 64 years of age and under, institutionalized in a non-Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredited facility designated by the U.S. Department of Health and Human Services (HHS) as an Institution for Mental Disease (IMD), or

   b) 21 to 64 years of age, institutionalized in a JCAHO accredited facility designated by the HHS as an IMD.

EMERGENCY SERVICES FOR MEMBERS

Emergency Services is defined as twenty-four hour emergency care for Members who present with conditions that are manifested by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention may result in placing the health of the individual or unborn child in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily organ or part. Emergency services also include care for an emergency psychiatric condition.

Services provided to Members presenting to an emergency department, including the Emergency Medical Screening Exam (which includes any services needed to determine if an emergency exists), and all services needed to stabilize any emergency condition, do not require prior authorization and must be paid for by the CHP network.

If the emergency department believes that services beyond stabilization of an emergency are medically indicated, they are required to obtain prior authorization. If they are unable to obtain a response to an authorization request within 30 minutes, they are automatically authorized to provide the services they deem necessary.

Emergency While at PCP's Office

If a Member requires emergency services while in the PCP's office, the staff shall implement their emergency procedures, etc., call 911 *or* refer the Member to the appropriate affiliated CHP emergency room. If in the opinion of the PCP, the delay in reaching a CHP emergency facility would endanger the health of the Member, the Member should be referred to the nearest emergency room.

Patient Calls PCP's Office & Requires Emergency Services

If a Member phones the PCP's office and requires emergency services, they should be referred to an appropriate affiliated CHP emergency room. If in the opinion of the PCP, the delay in reaching a contract CHP emergency facility would endanger the health of the Member, the Member should be referred to the nearest emergency room or to call 911.

Questions regarding emergency services or procedures should be directed to the CHP Utilization Management/Case Management/Pharmacy Review Line at (626) 299-5539 during regular business hours.

EMERGENCY SERVICES FOR MEMBERS (continued)

DHS EMERGENCY ROOMS	TELEPHONE #	ADDRESS
Olive View/UCLA Med Center	(818) 364-4320	14445 Olive View Dr., Sylmar 91343
LAC+USC Med Center	(323) 226-2622	1200 N. State St., L.A. 90033
Martin L. King Jr./Drew Med Center	(310) 668-4426	12021 Wilmington Ave., L.A. 90059
Harbor/UCLA Med Center	(310) 222-3520	1000 W. Carson St., Torrance 90509

CHP Out-Of-Area Medical Care

If an emergency occurs out-of-area ("out-of-area", for the purposes of determining "in-area" versus "out-of-area services", is defined as, the geographical area outside of Los Angeles County), the emergency services provider should call (626) 299-5539 during regular business hours to seek verification of eligibility and authorization for care. The telephone number on the back of the Member's CHP identification card – (800) 832-6334 -- is to be used after business hours, weekends, and holidays.

The CHP Case Manager, in collaboration with the out-of-area provider, will determine if and when it is medically appropriate to transport the patient to a CHP network hospital. Transportation will be coordinated or arranged by the Plan.

ANCILLARY SERVICES: PHARMACY, LAB & RADIOLOGY

PHARMACY:

CHP Members should present their Plan identification card to obtain pharmacy services. Prescriptions must be filled at either a DHS facility or a CHP contract pharmacy.

Use of Generic Drugs

CHP has developed a drug formulary (Exhibit B). CHP follows a policy of mandatory generic usage, which is pharmacologically and therapeutically justified. The CHP also utilizes a list of drugs (Exhibit C) which are exempt from the mandatory generic policy based on potential bioequivalency issues. Pharmacies will not substitute generic drugs for these brand name drugs. Any drug used from the Plan formulary and in generic form does not require prior authorization. Generic drug equivalents will be dispensed by the pharmacies unless the PCP specifies "Do Not Substitute."

Prior authorization is required before dispensing anabolic steroids and when pharmacy charges exceed three hundred dollars. If the dispensing pharmacist encounters a problem in entering the prescription into the online system, he/she should call the National Medical Health Card Systems, Inc. (NMHCS, aka "National", the CHP's contracted pharmacy benefit manager) at (800) 777-9216. If the problem cannot be resolved through National, the pharmacist should call the CHP's Utilization Management/Case Management/Pharmacy Review Line at (626) 299-5539.

To obtain prior authorization during business hours, the pharmacist is to call the CHP Utilization Management/Case Management/Pharmacy Review Line or fax the request to (626) 299-7267. For an after hours authorization, the pharmacist is to call (800) 832-MEDI.

Brand name drugs will only be available to Medi-Cal Members when medical necessity is certified by a physician. Brand name drugs will not be dispensed to Medi-Cal Members based solely on patient preference. Medi-Cal Members cannot be charged for pharmaceuticals.

Quantity to be dispensed

The maximum supply of a drug that may be dispensed at one time is a 7-14 day course for short duration drugs (e.g., antibiotics), and a 30-day supply for chronic drugs, unless the drug is included on the CHP maintenance drug list. A 100-day supply may be dispensed for drugs listed on the CHP maintenance drug list (Exhibit C).

A prescription may be issued for multiple months of refills, but it is the responsibility of the dispensing pharmacist to confirm Member eligibility each time the medication is dispensed.

ANCILLARY SERVICES - PHARMACY (continued)

Drugs Provided Under Emergency Circumstances

In accordance with Title 22 CCR, Section 53854(2), when the course of treatment provided under emergency circumstances requires drugs, a sufficient quantity of such drugs will be provided to the Member to last until the Member can reasonably be expected to have a prescription filled.

Formulary Drug Addition/Deletion Requests

Written recommendations with regards to additions or deletions to the formulary should be forwarded to the CHP, Chief Medical Officer, 1000 South Fremont Avenue, Building A-9 East, 2nd Floor, Unit 4, Alhambra, California 91803-8859. Upon review by the Chief Medical Officer, recommendations will be directed to the Pharmacy and Therapeutics Committee for review and determination.

Non-Prescription Therapeutic Interventions

PCPs are encouraged to counsel patients on non-prescription therapeutic interventions, whenever feasible. For example:

Allergic rhinitis:	Eliminate allergens from the environment
Anxiety:	Exercise, avoid stimulants, stress management techniques
Arthritis:	Weight loss, exercise program to strengthen supporting structures of involved joints, heat/ice therapies
Diabetes, Type ll:	Weight loss, diet and exercise
Dyspepsia:	Smoking cessation/ETOH/offending foods and drugs, Mg, Al Hydroxide
Hyperlipidemia:	Diet, smoking cessation, weight loss, salt restriction
Insomnia:	Sleep hygiene, exercise program, avoid stimulants
Asthma:	Avoid triggers (e.g., dust, cigarette smoke)
Hypertension:	Moderate alcohol use, weight control, salt restriction, exercise, smoking cessation
Strained Muscles:	Rest, apply ice/warm pack
Obesity:	Eating habits assessment, exercise, diet, establish goals on behavioral change

ANCILLARY SERVICES - PHARMACY (continued)

Esophagus-reflux/heartburn	Smoking cessation, avoid excessive alcohol, avoid certain foods and drinks (e.g. orange and tomato juices, chocolate, caffeine), eat smaller meals.

Medical Supplies That Can Be Supplied by a Pharmacy Services Contractor Without Plan Prior Authorization

The medical supplies listed on Exhibit B, page 13 [as included in Title 22, California Code of Regulations (CCR), Section 59998] may be provided to CHP Members by Pharmaceutical Services contractors, without prior Plan authorization, provided that a physician has prescribed them.

Any items not included in this list will require prior Plan authorization, which may be obtained by calling the Plans 24-hour Service Number (1-800-832-6334).

LABORATORY:

Each provider should use its affiliated laboratory service.

If a PCP performs any of the following nine laboratory tests on site, there must be a current CLIA (Clinical Laboratory Improvement Act) exemption certificate:

- Dip stick or tablet urinalysis
- Fecal occult blood
- Ovulation test using visual color comparison
- Urine pregnancy test using visual color comparison
- Hemoglobin by copper sulfate - (non-automated)
- Spun micro hematocrit
- Blood glucose, using certain devices cleared by the FDA for home use.
- Erythrocyte sedimentation rate (non-automated)
- Automated hemoglobin

Lab testing beyond these services will have additional CLIA requirements. Questions about CLIA and the exemption certificate can be phoned to the State Department of Health Services Lab Services Unit - LA Branch at (213) 620-6160. Berkeley Branch: (510) 873-6327.

RADIOLOGY:

Each provider should use its affiliated radiology service.

If pharmacy, laboratory and radiology services are not available on-site, CHP providers shall establish written service agreements with entities to provide these services.

NOTE: Contractors with a CHP Primary Care Only contract must refer CHP patients to DHS facilities for certain diagnostic tests. Refer to Exhibit C in the contractor's CHP Medi-Cal Managed Care Program Services Agreement for more detail.

SPECIAL CLINICAL SPECIFICATIONS, PROGRAMS AND SERVICES- SECTION 7

Overview

Linked/Carved-Out Services are services designated by the State Department of Health Services (SDHS) as benefits to Medi-Cal Members, and for which financial responsibility may be excluded from the Managed Medi-Cal Care contract and which are provided by specialized publicly funded linked and carved out service agencies.

Linked/Carved Out Agencies are State/Federal agencies which provide specified supplemental or wrap-around services to Medi-Cal Members and for which service the agency and not CHP is financially responsible except as specified (Family Planning, STD, Immunizations by LHD). These agencies include, but may not be limited to:

California Children's Services (CCS) Program,
Department of Developmental Services (DDS),
Department of Mental Health/Local Mental Health Plan (DMH/LMHP),
Alcohol and Drug Treatment Program
Women Infant and Children (WIC) Program,
Child Health Disability Prevention (CHDP) Program, and
Local Health Departments.

Specific information on these programs is discussed on the following pages of Special Clinical Specifications, Programs, and Services.

Coordination: CHP has liaisons (see page vi) to assist the PCP with care and service coordination and information regarding Member referral to and/or utilization of the special programs and services described in this section. The liaison shall educate the CHP Network providers, Utilization Management/Case Management nurses and other medical staff regarding Special Clinical Specifications, Programs, and Services.

To obtain more information about Linked and Carved Out Program services, providers should contact the Plan's UM/Case Management Unit at (626) 299-5539.

Monitoring

CHP/OMC will monitor the effectiveness of service coordination and Member referral to and/or utilization of special programs and services. Further information on monitoring is provided in the section on the CHP Quality Improvement Oversight Program.

ALCOHOL AND DRUG TREATMENT

Alcohol and Drug Abuse Treatment Services are available to Members and are provided as a carved out benefit through the Office of Alcohol and Drug Programs of L.A. County. The following services are provided by the Alcohol and Drug Programs:

Outpatient Methadone Maintenance
Outpatient Drug Free Treatment Services
Perinatal Residential Services
Day Care Habilitative Services
Naltrexone Treatment Services (Opiate Addiction)
Outpatient Heroin Detoxification Services

Primary Care Physicians are responsible for identifying a Member's need for alcohol and/or drug treatment. This includes identification of the following:

a. Chronic, crisis, or new presentation of alcohol or other substance abuse in the general membership population;
b. Adolescent alcohol or other substance abuse;
c. Alcohol or other substance abuse by pregnant women;
d. Candidates for heroin detoxification; and
e. A Member's self-identification as an alcohol or drug abuser in need of help.

Primary Care Physicians will evaluate the possibility of alcohol and/or substance abuse through:

- Initial health assessments,
- Prenatal care,
- Treatment for other medical conditions,
- Preventive examinations, and
- Emergency room or urgent visit encounters, or hospitalizations.

Referral for Treatment: When substance use is recognized as a potential condition, the PCP shall coordinate the provision of services by referring the Member to a treatment facility serving the geographic area. Referral is done by using the substance abuse referral form or by referral to the Community Assessment Services Center (CASC) toll free number (800) 564-6600. The CASC will assist PCP's in locating the appropriate referral to County programs. Members can access substance abuse treatment services by self-referral, by a family referral or referral from the PCP or other appropriate provider. CHP Providers must also provide other necessary medical care to Members while they are in a detoxification program.

ALCOHOL AND DRUG TREATMENT (continued)

Short-Doyle Drug Medi-Cal (SD/MC) covers the services listed and described below:

- Outpatient Methadone Maintenance: includes intake, evaluation assessment and diagnosis, treatment planning, medical supervision, urine drug screening, physician and nursing services related to drug abuse, individual group counseling, admission physical examinations and laboratory tests, medication services, collateral services, crisis intervention, and the provision of methadone as prescribed to alleviate the symptoms of withdrawal from narcotics.

- Outpatient Drug Free Treatment Services: includes intake physical examinations, intake evaluation, assessment and diagnosis, medical supervision, medication services, urine drug screens, treatment and discharge planning, crisis intervention, collateral services, group counseling, and individual counseling.

- Perinatal Residential Drug Abuse Services: includes intake, assessment, admission physical examinations and laboratory tests, diagnosis, medical direction, individual and group counseling services, education on alcohol and other drug problems, parenting education, urine drug screens, medication services, collateral services, and crisis intervention services. Does not include room and board and must be provided in a licensed residential facility with 16 or less adult beds.

- Day Care Habilitative Services: provided only to pregnant and postpartum women and EPSDT-eligible beneficiaries and include intake, assessment, diagnosis, evaluation, admission physical examinations, treatment planning, individual and group counseling, urine drug screens, medication services, collateral services, and crisis intervention.

- Naltrexone Treatment Services (for opiate addition): includes intake, assessment, evaluation, diagnosis, admission physical examinations, provision of medical services, medication direction, physician and nursing services related to drug abuse, urine drug screens, individual and group counseling, collateral services, and crisis intervention.

Coordination and Follow-Up Care: Once a Member is referred to, screened, and accepted for alcohol and/or drug treatment, the PCP is responsible for coordinating care and providing follow-up care. Coordination includes:

ALCOHOL AND DRUG TREATMENT (continued)

a. Providing coordination of care between systems.
b. Ensuring patient confidentiality by complying with medical records release requirements and confidentiality policy.
c. Tracking the Member's progress through detoxification, treatment, and follow-up in both outpatient and inpatient settings.
d. Assessing the Member's medical condition upon discharge from treatment.
e. Working to enhance the health status of the Member's pregnancy through referral to WIC, health education, and psycho-social counseling by integrating with comprehensive perinatal services teams.

CALIFORNIA CHILDREN SERVICES

California Children Services (CCS) is a Statewide program that arranges and pays for medical care, equipment, and rehabilitation when the services are authorized by the program. CCS will authorize services for children and young adults under 21 years of age who have eligible conditions and whose families are unable to pay for all or part of the care. CCS defines eligibility and selects the most qualified professionals to treat the child's CCS eligible condition.

Plan providers are responsible for the process of condition identification, referral, and coordination of care for CCS eligible Members, as well as the provision of all primary care and specialty care not related to the CCS eligible condition of a Member.

Identification

If a potential CCS eligible condition is identified (Exhibit L), the PCP will inform the local CCS Department to initiate an evaluation.

Referral

CCS referral forms (Exhibit M) are to be available in all PCPs offices. CCS should be contacted for assistance as requests for coverage must be made on or before the day services are rendered, except for emergencies. CCS eligibility must be determined before CCS can cover services.

CCS referrals can be mailed or a fax sent to:

California Children Services
9320 South Telestar Avenue, Suite 226
El Monte, CA 97331
Fax (800) 924-1154
Telephone: (800) 288-4584

<u>Standard Referrals</u>

PCPs are to notify the CHP Program Liaison when they encounter a problem in referring a Member to CCS.

- The PCP may refer the potentially eligible Member to an appropriate CCS panel provider for confirmation of a CCS eligible diagnosis, if there is any question of eligibility, and upon confirmation initiate completion of the CCS form. However, the PCP and/or Member's family may also directly apply to CCS by requesting a Program Application (Exhibit M) referral from the PCP's office.

CALIFORNIA CHILDREN SERVICES (continued)

Emergency Referrals are accomplished by telephone and/or fax communication between the PCP and the CCS panel specialist.

Care Coordination

The CCS-eligible Member's PCP is the overall Case Manager for the Member. PCP responsibilities include:

- Diagnosis
- Notification to local CCS Department regarding potential CCS eligibility
- Initiation of referral for CCS condition
- Provision of primary care services and preventive care, including immunizations
- Referral for specialty care not related to CCS-eligible condition
- Coordination of care
- Maintenance of comprehensive medical record on CCS-eligible Member

Overview of CCS Medically Eligible Conditions

The following is a list of possible eligible medical conditions. Many situations will require final determination by the local CCS Program.

- Infectious Diseases
- Neoplasms
- Endocrine, Nutritional, Metabolic Diseases, Immune Disorders
- Diseases of Blood and Blood-Forming Organs
- Mental Disorders and Mental Retardation
- Diseases of the Nervous System
  Diseases of the Eye
- Diseases of the Ear and Mastoid
- Diseases of the Circulatory System
- Diseases of the Respiratory System
- Diseases of the Digestive System
- Diseases of the Genitourinary System
- Diseases of the Musculoskeletal System and Connective Tissue
- Congenital Anomalies
- Certain Causes of Perinatal Morbidity and Mortality
    - Neonates who have a CCS eligible condition and require care in a Neonatal Intensive Care Unit (NICU).
    - Critically ill neonates who do not have an identified CCS eligible condition but who have sometime between 0-28 days developed a disease or condition that requires one or more of the following services in an NICU (invasive or non-invasive ventilatory assistance, FIO2 greater than 60 %

CALIFORNIA CHILDREN SERVICES (continued)

for over 24 hours, umbilical artery or arterial catheter, CVP for hyperalimentation, or chest tube).

- Neonates and infants who do not have an identified CCS-eligible condition but who develop a disease or condition which requires two or more of the following services in NICU. (Ten or more episodes of apnea and bradycardia which requires either external stimulation or treatment with medications such as theophylline or caffeine, pulmonary percussion, vibration, and suction every 6 hours or at least 4x a day, supplemental O2 greater that 48 hours, peripheral IV line for medications or IV fluids including hyperalimentation, tracheal suctioning every hour, continuous gavage feeding every 2 hours or less, or oral feeding requiring more than 30 minutes)
- Accidents, Poisonings, Violence, and Immunization Reactions

For a more detailed list of medically eligible conditions, refer to CCS Medical Eligibility regulations, Title 22, Sections 41800 through 41872 located in Exhibit L.

CCS Special Care Center Services

Children with complex, disabling conditions receive improved care and achieve better long-term care outcomes when services are provided and coordinated through CCS Special Care Center. These are located at a tertiary medical center and consist of multidisciplinary teams who plan and carry out comprehensive, coordinated care for groups of illnesses, generally based on a particular organ system. Children with the following conditions should be referred to a CCS approved Special Care Center for evaluation and treatment recommendations:

- congenital heart disease
- inherited metabolic disorders
- chronic renal disease
- malignant neoplasm
- hemophilia and other coagulopathies
- hemoglobinopathies
- craniofacial anomalies
- myelomeningocele
- endocrine disorders, including diabetes
- congenital and acquired immunologic disorders

CALIFORNIA CHILDREN SERVICES (continued)

Routine Flow of Patient Specific Activities

The following descriptions attempt to define terms and clarify the way in which services are initiated and provided as a routine within the CCS program. Naturally, emergency services for new and continuing patients will alter this pattern. Please refer to Exhibit L.

Referral Reporting

CHP Providers are required to report each month to the Plan the number of CHP Medi-Cal Members referred to CCS. The report must include at a minimum the following:

- Member's name
- Member's identification number
- Date referred to CCS ICD-9 code or diagnosis

CONFIDENTIAL HIV TESTING AND COUNSELING

Members may access confidential HIV testing and counseling services through CHP providers as well as through out-of-network/out-of-plan providers, including HIV testing and counseling providers funded through the Local Health Department Clinics, Family Planning Clinics, and Prenatal Clinics.

Any or all three (3) health departments within L.A. County may provide a variety of public health services. The three (3) local Health Departments servicing L.A. County residents include Los Angeles County Department of Health Services (LAC/DHS), the Long Beach Health Department, and the Pasadena Health Department.

For information on anonymous and confidential testing, contact:

Office of AIDS Programs and Policies
600 S. Commonwealth, 6th Floor
Los Angeles, CA 90005
(213) 351-8000

California and Federal laws prohibit a health plan from requiring that a Member receive authorization prior to accessing these services. As such, Members have the right to seek these services with any provider within or outside of CHP's provider network. Provider Groups will not require that a Member receive authorization prior to accessing these services.

Informing Members

Members have the right to access confidential HIV testing and counseling services. Information about these services, including sites funded by the Los Angeles County DHS, is provided in the enrollment materials as well as in posters, newsletters, brochures, and other health education activities. These informational and promotional efforts will be made in conjunction with other STD-related activities.

PCPs will encourage Members, particularly those identified for being at high risk, to seek HIV testing and counseling services. All Members who are tested for HIV must complete and sign an HIV test consent form, prior to the performance of the test.

Confidentiality

The results of the HIV tests are confidential and State and federal law strictly limit disclosure. An HIV test is defined to mean any clinical laboratory test used to identify HIV, a component of HIV, or antibodies or antigens to HIV.

CONFIDENTIAL HIV TESTING AND COUNSELING (continued)

Enhanced Reimbursement for Provider Groups

CHP will reimburse Plan Provider Groups an AIDS benefit rate (ABR) enhancement for Members who have a confirmed diagnosis of AIDS.

A confirmed diagnosis of AIDS means a diagnosis of AIDS which has been formally recorded, dated, and signed by a treating Physician in the AIDS Beneficiary's Medical Record. The diagnosis must use the definition of AIDS adopted by the Centers for Disease Control and Prevention (CDC), United States Department of Health and Human Services, for the month in which the diagnosis was made.

To receive the ABR, providers must submit a Confidential Billing Form and supporting documentation that reflects the month and year the AIDS diagnosis was initially made to the CHP, Utilization/Case Management Unit.

Confidential Billing Forms may be obtained by calling the CHP Utilization Management/ Case Management/Pharmacy Review Line at (626) 299-5539.

Members Who Test Positive for HIV

If Members select HIV testing and services through their PCP, the PCP serves as the Member's care coordinator for treatment services within the network. If a Member tests positive for HIV at an out-of-network test site or from a Local Health Department , the Member should be referred back to the PCP to ensure appropriate care coordination. The PCP has the primary responsibility for appropriate treatment and Case Management of the Member according to the following provisions:

- Follow protocols recommended by the Centers for Disease Control (CDC), and the National Institutes of Health (NIH)
- Provide timely referral for further counseling services
- Provide timely referral to a qualified network specialist for disease specific case management, as appropriate (e.g., Pulmonology, Infectious Disease, Gastroenterology, Neurology, Oncology, nutrition counseling, substance abuse, psychosocial support and mental health care)
- Confidential copying transferring of all pertinent medical documentation to a referral provider, as is appropriate, in accordance with applicable confidentiality regulations
- Report HIV cases to the County Public Health Department.
  [AIDS Case Report Forms may be obtained by calling the HIV Epidemiology Program at (213) 351-8516.]

Reimbursement for Out-of Plan Services

CHP will reimburse out-of-plan/out-of-network providers for confidential HIV testing and counseling services.

DENTAL SERVICES

Dental Services is not a covered benefit, however, PCPs are to perform inspection of teeth and gums for any signs of infection, abnormalities, malocclusion, inflammation of gums, plaque deposits, caries or missing teeth. If any of the above conditions are observed, PCPs are to make prompt referral to a dentist, if necessary.

The PCPs are to document screenings and referrals in the Member's medical record.

As part of the CHDP health assessment, children at the age of three are to be referred to a Medi-Cal dentist if a dentist has not seen them within the prior six months. Dental screenings of adults are accomplished, at a minimum, as part of the periodic examinations recommended by the United States Preventive Services Task Force as well as in the course of other encounters. PCPs are to be encouraged to educate Members about the importance of dental care and to make corrective and preventive referrals.

EARLY INTERVENTION

Members who are children (birth through 36 months) in need of early intervention services will be referred to an Early Start Program in Los Angeles County. These include children with an established condition leading to developmental delay, those in whom a significant developmental delay is suspected, or those whose early health history places them at risk for delay. Please refer to SDHS, Medi-Cal Managed Care Division (MMCD) Letter #97-02 (January 29, 1997) for information pertaining to Early Intervention Services: Part H Early Start Program (Exhibit N). Contact the Plan's Case Management Department at (626) 299-5539 for more information.

Clinical Identification and Referral

The following conditions are among those which potentially place infants and children at risk for developmental disabilities:

- HIV/AIDS
- Cancer
- Blindness, hearing impaired
- Retardation
- Heart conditions
- Epilepsy
- Juvenile diabetes
- Cleft palate
- Lung disorders, asthma, cystic fibrosis

EARLY INTERVENTION (continued)

- Downs syndrome
- Physically handicapped due to extensive orthopedic problems
- Neurologically impaired, spinal cord injuries
- Sickle cell anemia

CHP PCPs are to identify children who are at risk for developmental disabilities and refer them to the Early Start Program within two working days of the assessment results. The PCP may provide either a written or telephone referral. The parents may also be provided with the telephone numbers and addresses of Early Start Programs so they may contact them for evaluation and a determination of their child's eligibility for services. The PCP should assist parents by making Early Start Program referrals as specific as possible, stating the reason for referral and arranging for forwarding supporting information within one week. This information includes the following:

- Results of vision and hearing screening,
- Medical history, and
- Results of developmental screening.

PCPs may assist parents by calling the local Early Intervention Program intake office at 1(800) 515-2229 to determine eligibility and identify programs for infants and children who are determined to be eligible for services. The PCP shall continue to case manage and provide the child's primary care services and referrals unrelated to the developmental disability.

Coordination of Services

CHP benefits cover all medically necessary diagnostic, preventive and treatment services, health and medical assessments, and procedures required by Medi-Cal for infants and young children at risk for having developmental disabilities.

If the Member is eligible for both California Children's Services (CCS) and Regional Center Early Start Program, the primary referral is to be made to CCS if the diagnosis or treatment of the CCS eligible condition is the major concern. The PCP may notify the Early Start program and the CCS program simultaneously if both medical and early intervention services are necessary

EARLY INTERVENTION (continued)

Resources

Regional Centers: The Los Angeles County Regional Centers are Early Start Program resources for parents with questions about services for disabled children. A list of Regional Centers can be found on Exhibit O.

EARLY AND PERIODIC, SCREENING, DIAGNOSIS, AND TREATMENT SERVICES

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services, including EPSDT supplemental services, are any services a State is permitted to cover under Medicaid law that are medically necessary to correct or ameliorate a defect, physical and mental illness or condition for a Member under the age of twenty-one (21), if the service or item is not otherwise included in the State's Medicaid plan.

CHP Providers will ensure that:

- -- Needed EPSDT services, including Case Management, are identified and provided for eligible Members.
- -- Members are referred to EPSDT screening services (which include CHDP)
- -- A Member's need for EPSDT services is evaluated within the initial 120 days of enrollment.
- -- A Member's receipt of EPSDT services is overseen, monitored, and coordinated by the PCP, whether delivered by a CHP or out-of-plan provider.

PCP's are required to provide adequate screening and immunization services to Members as follows:

Initial Health Assessment Within 120 Days of Enrollment (for adult Members)

Initial Health Assessment Within 60 Days of Enrollment (for Members under 18 months of age)

Periodic Preventive Visits – Children's Preventive Services at the times specified by the most recent American Academy of Pediatrics (AAP) periodicity schedule.

EARLY AND PERIODIC, SCREENING, DIAGNOSIS, AND TREATMENT SERVICES (continued)

As part of the periodic preventive visit, all age specific assessments and services required by the EPSDT/CHDP program, as necessary are to be provided:

Immunizations
Blood Lead Screen
Screening for Chlamydia
EPSDT Supplemental Services when necessary
Behavioral Health

As exceptions, CHP Providers are not responsible for payment for services provided under CCS, or for Case Management services provided by a State-conducted referral provider such as a Regional Center.

Prior Authorization

Upon a CHP Provider's identification of the need for EPSDT services, including EPSDT supplemental services that are not covered services under their capitation payment, the CHP Provider must provide the Member with a referral to an appropriate provider or organization.

CHP is not obligated to reimburse Out-of-Plan providers for EPSDT screens that were not authorized. CHP Providers must, however, ensure that all referrals and the referral outcomes are documented in the Member's medical record.

EPSDT Supplemental Services

These are services for Medi-Cal Members under the age of 21 years, as defined in Title 22, CCR, Section 51184 and as revised from time to time in MMCD policy letters, as follows:

Case management and supplemental nursing services
Targeted case management services designed to assist children in gaining access to necessary medical, social, educational, and other services
Any service required to treat or ameliorate a condition identified on an EPSDT visit, regardless if specifically identified as a Medi-Cal benefit

EARLY AND PERIODIC, SCREENING, DIAGNOSIS, AND TREATMENT SERVICES (continued)

Medical Necessity

Requested EPSDT supplemental services must meet the following medical necessity criteria:

- The services requested meet specific requirements for orthodontic dental services or provision of hearing aids or other hearing services.
- The services requested are to correct, or ameliorate a defect, physical or mental illness, discovered by an EPSDT screening.
- The supplies, items and/or equipment requested are medical in nature.
- The services requested are not solely for the convenience of the Member, the family, the physician or any other provider of service.
- The services requested are not primarily cosmetic in nature or designed to primarily improve the Member's appearance.
- The services requested are safe and are not experimental and are recognized as an accepted modality of medical practice.
- The service requested, when compared with alternatively acceptable and available modes of treatment, are the most cost effective.
- The services requested are within the authorized scope of practice of the provider and is an appropriate mode of treatment for the medical condition of the Member.
- The services requested improve the overall health outcome as much as, or more than, the established alternatives.
- The predicted beneficial outcome outweighs potential harmful effects.

EPSDT supplemental services include, but are not limited to the following:

- Case Management services
- Cochlear implants
- Home nursing
- Psychology
- Occupational therapy
- Audiology
- Orthodontics
- DME (in certain instances)
- Hearing aids
- Mental health evaluation and services
- Medical nutrition services assessment and therapy
- Pharmacy
- Physical therapy evolution and services
- Pulse oximeters
- Speech therapy

SCHOOL BASED CHDP SERVICES

A memorandum of understanding (MOU) for a School-Based Services Agreement is in place with the School Districts for the purpose of coordinating services provided by the School District or sites under the CHDP program.

The PCP is responsible for providing basic case management for the Member and follow-up and coordinate the provision of any referrals or additional services necessary to diagnosis and/or treat conditions identified during the school EPSDT/CHDP assessment. The PCP will also provide ongoing preventive and primary services.

FAMILY PLANNING SERVICES

Members may access Family Planning Services both within and outside of CHP's network of providers on a self-referral basis without prior authorization (referred to as Family Planning Freedom of Choice). CHP will reimburse out-of-plan providers for Family Planning Services provided to Members. MMCD Policy Letters 98-11, 95-03, and 94-13, which speaks to Family Planning Freedom of Choice, is provided in Exhibit Q.

Family planning includes the services listed below.

- Health education and counseling services necessary for Members to make informed choices and understand contraceptive methods.
- Limited history taking and physical examinations. PCPs or OB/GYNs are responsible for the comprehensive history taking and physical examinations.
- Laboratory tests, if medically indicated for the chosen contraceptive method. Pap smears, if not provided per USTP guidelines by PCPs or OB/GYNs.
- Diagnosis and treatment of sexually transmitted diseases (STD), if medically indicated.
- Screening, testing, and counseling of individuals at-risk for HIV and referral for treatment for HIV-infected Members.
- Follow-up care for complications associated with contraceptive methods issued by the Family Planning provider.
- Provision of contraceptive pills, devices, and supplies, including Norplant. CHP providers will be required to obtain informed consent for all contraceptive devices.
- Tubal ligation.
- Vasectomies.
- Pregnancy testing and counseling.

FAMILY PLANNING SERVICES (continued)

Informing Members and CHP Providers

CHP Members are informed of Family Planning Freedom of Choice provisions through the Member Handbook. Members receive information, including a list of out-of-plan Family Planning providers, in the Member Handbook and membership update material and educational presentations.

Procedures for Out-Of-Plan Family Planning Services

The following procedures will be utilized for out-of-plan Family Planning Services:

- To access services from a CHP provider or out-of-plan/out-of-network provider, a Member may self-refer and call the provider for an appointment.

- The provider may call the CHP Member Services Line at (800) 475-5550 for eligibility information.

Confidentiality

The provision of Family Planning Services is confidential. Out-of-plan/out-of-network providers are encouraged to make every effort to provide required information for care coordination and reimbursement while maintaining Member confidentiality.

Out-of-plan providers are requested to encourage CHP Members to release their medical records to their PCP. For those Members who do not consent to release of medical records information, the out-of-plan/out-of-network provider must submit a list of services, for reimbursement purposes, utilizing only the Member's identification number.

HOME AND COMMUNITY- BASED SERVICES WAIVER PROGRAM (DEPARTMENT OF DEVELOPMENTAL SERVICES)

The Home and Community Based Services (HCBS) Waiver Program is administered by the State Department of Developmental Services (DDS) through local Regional Centers (Exhibit O) and provides community-based services for a limited number of developmentally disabled Medi-Cal beneficiaries who live in the community but are at risk for institutional placement.

Suspected and Diagnosed Developmental Disabilities

Children over 36 months of age and adults who fall four to six months below age-appropriate parameters (on a case-by-case basis) and those with the conditions listed below are to receive HCBS Waiver Program eligibility evaluation:

- Mental Retardation (ICD9 315 and 319)
- Cerebral Palsy (ICD9 343)
- Seizures (ICD9 345)
- Autism or similar conditions (ICD9 299)

HCBS Waiver Program Services

HCBS Waiver Program services include home health aide services, respite care, rehabilitation services, skilled nursing, adult day health care, and personal care and other non-medical services.

Identification, Referrals and Coordination of Care

Identification

The PCP should screen for DDS eligible conditions during the initial 120 day IHA assessment and during on-going periodic visits. Refer to Exhibit R for a list of ICD9 codes of potential eligible DDS conditions.

A list of potential and eligible DDS Members identified by CHP will be provided to PCP's to facilitate the provision of basic case management and coordination of care.

Referral

Provider Groups may utilize network providers for diagnosis and treatment of Members with developmental disabilities, but members must have the required services and be

HOME AND COMMUNITY- BASED SERVICES WAIVER PROGRAM (continued)

referred to Regional Centers if services are needed and not available within the network.

The PCP may make a referral to a Regional Center (RC) upon clinical evaluation and if desired by the Member or his/her parents if a minor. The Member's disability must originate before he/she attains 18 years, be expected to continue indefinitely, and constitute a substantial handicap.

The PCP or specialist should refer potential and eligible Members directly to the RC's intake coordinator and should include the following information:

- the reason for the referral
- complete medical history and physical examination, including appropriate developmental screens; and
- the results of developmental assessment/psychological evaluation and other diagnostic tests as indicated.

CHP, Provider Groups, and PCPs are to ensure confidential transfer of medical documentation in compliance with all Federal and State regulations.

RC Medical Consultants are available for consultations on appropriate medical tests necessary for obtaining a specific diagnosis.

Members (parent/guardian) may self refer to the Regional Centers for confirmation of Regional Center eligibility criteria

Coordination

The PCP will continue to provide all primary care and other medically necessary services and be responsible for basic case management and coordination of care including referrals for Members receiving HCBS Waiver Program services. Documentation of referral to Regional Center and coordination of care must be maintained in the Member's medical records.

The HCBS Waiver Program provider will bill DDS for those services. CHP Providers retain responsibility for payment for all other Medi-Cal services covered in the capitation payment.

Members not meeting criteria for care in an HCBS Waiver Program, or if placement is not available, will continue to be case managed by the PCP.

LONG-TERM CARE

Members who need to be placed in a long-term care facility longer than the month of admission plus an additional month are to be disenrolled and placed in such a facility through fee-for-service Medi-Cal.

PCP's are responsible for the process of condition identification, referral, and coordination of care, as well as the provision of all primary care and specialty care not related to the long term care needs of Members.

Identification of Need and Placement

CHP providers must ensure that Members are identified and placed in facilities providing the appropriate level of care which is commensurate with their medical needs.

The California Children Services (CCS) covers many conditions which would require long term care for children. See the CCS section in this manual for contact information.

Inpatient Concurrent Review: If a Member is admitted to a long-term care facility, the procedures below will be followed.

- The PCP's or facility's UM staff will notify their Member Services Department of Members in long term care longer than the month of admission, plus one month, for potential disenrollment action.
- If it is anticipated that a Member will require long-term care in the facility for longer than the month of admission plus one month, the facility's Member Services Department will notify CHP Member Services Hotline at (800) 475-5550. CHP Member Services initiates the disenrollment process and transfers the Member to fee-for-service Medi-Cal.
- If disenrollment is not approved and the Member continues to need services, the facility's UM staff is to place the Member in long term care and notify the facility's Case Manager for follow-up.

The PCP will continue to provide Case Management and follow-up to assure that all of the Member's health needs are being addressed, including all primary care and specialty care not related to the long-term care needs of the Member for as long as the Member remains enrolled in CHP.

Disenrollment and Continuity of Care

The PCP will ensure that the Member's medical records and all other appropriate information are transferred to the Member's fee-for-service provider when disenrollment

LONG-TERM CARE (continued)

occurs. If the Member's PCP continues to act in this capacity under fee-for-service Medi-Cal, the long term care facility must be notified of this.

Until disenrollment is effective, the PCP will be responsible for providing all medically necessary covered services to the Member.

MAJOR ORGAN TRANSPLANTATION

Major organ transplants are excluded CHP services, except for cornea and kidney transplants. Members who are approved by SDHS for other major organ transplants will be disenrolled from CHP and covered by fee-for-service Medi-Cal.

Medi-Cal Approved Organ Transplantation

- Bone marrow transplants
- Heart transplants
- Lung and Heart-lung transplants
- Liver transplants
- Liver-kidney combined transplants
- Liver-small bowel combined transplants

Identification, Evaluation, and Authorization

In most instances, PCP's, and/or their referral specialist will identify potential transplant candidates. When the Member is identified as a potential transplant candidate, the Provider Group is responsible for the following:

Referring the Member to be evaluated by a Medi-Cal approved transplant center.
Authorizing the evaluation, including labs and x-rays
Notifying CHP Case Management.

The CHP Case Management Department is responsible for overseeing and facilitating coordination of activities between PCP's, Provider Groups', SDHS, and transplant centers.

If the transplant center physician considers the Member to be a suitable candidate, the transplant facility must submit a treatment authorization (TAR) to the State Medi-Cal Field Office.

MAJOR ORGAN TRANSPLANTATION (continued)

Disenrollment

Upon receiving notification (of a Medi-Cal approved TAR) from the transplant facility, the Provider Group is responsible for notifying CHP Member Services and Case Management. CHP Member Services will initiate disenrollment of the Member when the following has occurred:

Referral of the Member to a Medi-Cal approved organ transplant facility.
The facility's evaluation concurred that the Member is a candidate for an organ transplant.
The transplant is properly authorized and a signed TAR from the Medi-Cal field office is received

Provider Groups are responsible to cover the evaluation and health care services until the Member is disenrolled from CHP.

The effective date for the disenrollment is retroactive to the beginning of the month in which the transplant is approved by SDHS. All services provided during this month are billed as fee-for-service Medi-Cal.

If the Member is evaluated and determined not to be a candidate for a major organ transplant, or SDHS denies authorization for a transplant, the Member is not disenrolled. In this case, the PCP/Provider Group is responsible for continuing treatment of the Member.

Cornea and Kidney Transplants

CHP is financially responsible for cornea and kidney organ transplants, as such, the Provider Group shall inform the OMC CHP Case Management Unit by calling (626) 299-5539 within two (2) business days of any potential transplant cases. Kidney transplant Members may qualify for ESRD-Medicare benefits.

The identification, referral, evaluation, and authorization of potential cornea and kidney transplants are the responsibility of the PCP/Provider Group. OMC CHP will authorize the transplant when all of the following have occurred:

- Referral of the Member to a Medi-Cal approved organ transplant facility
- The facility's evaluation concurred that the Member is a candidate for a~~n~~ cornea or kidney organ transplant.

MAJOR ORGAN TRANSPLANTATION (continued)

The Provider Group/PCP is responsible for follow-up care and continuing treatment after the transplant.

Medi-Cal Approved Transplant Facilities

Heart Transplant Centers

UCLA Center
Loma Linda University Medical Center
USC University Hospital
Cedars-Sinai Medical Center
St. Vincent Medical Center

Lung and Heart-Lung Centers

USC University Hospital (approved for **lung** only)
UCLA Medical Center
Cedars-Sinai Medical Center

Liver Transplant Centers

UCLA Medical Center
Cedars-Sinai Medical Center
University of California Irvine Medical Center
Loma Linda University Medical Center
USC University Hospital
St. Vincent Medical Center

Intestinal Transplant Centers

UCLA Medical Center

Transplant Activity Logs

Provider Groups are required to report all organ transplantation activities to CHP Utilization Management/Case Management Department (Specialty Referral Logs and Case Management Activity Logs), who will in turn report the activities to L.A. Care. These logs track the following:

Member Name
Diagnosis
Referral Date
Recommendation/non recommendation for transplant approval
Submission of Treatment Authorization Request (TAR)
Approval/denial/appeal/reconsideration

MEDI-CAL WAIVER PROGRAM

IDENTIFICATION AND COORDINATION OF POTENTIAL CANDIDATES FOR THE MEDI-CAL WAIVER PROGRAM

Plan providers will ensure that Members identified as meeting candidate criteria, by diagnosis and level of care, for the Medi-Cal Waiver Program are evaluated for suitability. Members suitable for the Medi-Cal Waiver Program are:

- Members who have been in a skilled nursing facility (SNF) beyond 30 days without improvement and unable to maintain self-care
- Members in custodial care
- Members with an AIDS diagnosis (not required to disenroll from CHP)
- Members with other factors as noted in specific waiver criteria (see the attachments at the end of this section)

CHP Member Services will arrange the Member's disenrollment (excluding Members with an AIDS diagnosis) and transfer of care to fee-for-service Medi-Cal, thereby enabling the Member to receive care appropriately and safely in a home environment rather than an institution.

Identification

The Provider Group's Utilization Management/Case Management (UM/CM) Nurse will complete the steps listed below to identify candidates for the Medi-Cal Waiver Program.

- Screen all inpatient admissions for post-acute care, including home health care, SNF placement, rehabilitation services, and outpatient therapy as included in routine discharge planning screening, using the criteria in the attachments.
- Assess the Member's needs and determine the appropriate level of care (subacute care, SNF, or intermediate care facility) based upon level of care and medical criteria.
- Present the case to the CHP Provider Group's Medical Director for review if the Member requires ongoing care at the levels and duration appropriate for the Medi-Cal Waiver Program. The CHP Provider Group's Medical Director will consult with the Primary Care Physician to:

    - - Review care alternatives.
    - - Recommend the Member be disenrolled and transferred into the Medi-Cal Waiver Program, if indicated.

MEDI-CAL WAIVER PROGRAM (continued)

Coordination

If the CHP Provider Group's Medical Director approves the case, the Provider Group UM/CM Nurse will:

- Prepare a TAR for the Medi-Cal Waiver Program.
- Submit the TAR to the appropriate Medi-Cal field office with complete documentation of medical information.
- Notify the Member and the PCP of response from the Medi-Cal Waiver Program.

If the Member is accepted, the facility's Member Services Department will complete a disenrollment request form and forward it to CHP Member Services Department. The CHP Member Services Department will notify the facility's Member Services Department of the date of disenrollment.

Failure to Meet Criteria or Denial of Placement

If it is determined that the Member does not meet the criteria for the Medi-Cal Waiver Program or if placement is not available, the PCP will continue to be responsible for the Member's care.

If the Member is approved but denied placement because of unavailable spots, the PCP and Provider Group UM/CM Nurse will maintain contact with the appropriate agency to assure the Member is reconsidered when space is available.

PREGNANCY AND POSTPARTUM SERVICES

Pregnant Members are to be provided comprehensive, multidisciplinary pregnancy and postpartum services with case coordination. Multidisciplinary team discussion must include obstetrics, risk assessment/reassessments, health education, nutritional services, and psychosocial conditions and services in accordance with the standards of the American College of Obstetrics and Gynecology (ACOG), the Comprehensive Perinatal Services Program (CPSP) specifications of Title 22 of the California Code of Regulations, and the provisions set forth below. Please reference Exhibit G-ACOG Antepartum Record, Exhibit H-CPSP Prenatal Protocols, and Exhibit I-CPSP Postpartum Protocols.

PREGNANCY AND POSTPARTUM SERVICES (continued)

Case Coordination Elements

Antepartum Evaluation

Case coordination is the responsibility of the obstetric physician, although responsibilities for care coordination may be delegated to a team Member who is accountable to the obstetric physician.

The first prenatal visit is to be scheduled as soon as possible, not later than seven days after the Member's request for services. If the Member presents with adverse symptoms, then the antepartum visit must be scheduled in less than seven days. The guidelines to be followed for return visits are:

- Member with uncomplicated pregnancy should be seen every four weeks for the first 28 weeks of pregnancy, every two-to-three weeks until 36 weeks gestation, and weekly thereafter;

- Members with active medical or obstetric problems should be seen more frequently, as needed.

- The Provider's office must follow-up with a Member who has missed a scheduled appointment, with a telephone call. If no response, a follow-up letter must be sent to the Member. If there is still no response within two weeks, the Provider's office must refer the situation to the CHP/OMC Case Manager for follow-up assistance.

The first perinatal visit shall include an initial comprehensive risk assessment. Thereafter, risk assessment will be carried out at least once every trimester.

Each perinatal visit must include the following clinical measurements:
Weight, blood pressure, fetal size and position, fundal height, edema status, fetal heart tones, urine screening for glucose and protein, nutritional counseling, and health education pertinent to gestational age.

Related Programs (e.g., CPSP, WIC, family planning and dental services) Providers are to inform Members of pregnancy and perinatal related programs and refer Members to them when appropriate. Multidisciplinary teams shall engage in conferences and discussions on pregnancy conditions/issues, postpartum conditions/issues, and conditions/issues requiring referral to CPSP, WIC, CHDP, family planning, dental, nutrition, health education, psychosocial, and other related programs.

PREGNANCY AND POSTPARTUM SERVICES (continued)

Postpartum Evaluation

Each Member must receive a nutritional assessment two to four weeks after delivery.

The assessment must include the following:

- Identify any nutritional risk factors which may compromise the health of the client or her infant following the delivery;
- Identify and support the strengths/habits which promote good nutrition status following pregnancy and during breast feeding;
- Make timely and appropriate nutrition interventions for each Member;
- Integrate postpartum nutrition care with obstetrical, psychosocial, and health education services, including development of a nutrition care plan and WIC referral when appropriate.

The routine post postpartum care should be scheduled 21-56 days after delivery. The visit should include:

- History, including questions regarding breast feeding;
- Physical examination, including laboratory data as indicated;
- Family planning counseling;
- Nutritional, health education, psychological, and social reassessment;
- Review of immunizations, including rubella immunization; and
- Encouragement to return regularly for examinations.

Comprehensive Perinatal Services Personnel

The primary component of quality multidisciplinary comprehensive perinatal care is the quality of the personnel. Participating obstetrical providers must ensure that health education, nutrition, psychosocial, assessment, reassessment and interventions are administered by qualified personnel.

PREGNANCY AND POSTPARTUM SERVICES (continued)

Medical Protocols

Providers are to utilize the protocols and tools provided in Exhibits G - I. These are consistent with ACOG standards and CPSP regulations. Each facility and Provider Group providing CPSP services shall initialize their CPSP protocols to list their core practitioners/delivery team.

CPSP delivery team models include: Hospital-Based teams, obstetrician or Provider Group office-based teams, contracted office-based, and clinic-based or mobile teams.

The core practitioners may include the General Practice physician, Family Practice physician, Pediatrician, OB/GYN, Certified Nurse Mid-Wife, Registered Nurse, Nurse Practitioner, Physician's Assistant, Social Worker, Health Educator, Childbirth Educator, Registered Dietitian, and Comprehensive Perinatal Health Worker.

In addition, the CPSP provider must maintain a list of the ancillary staff and programs who may deliver care, including: Geneticists, public health, substance abuse prevention, community based organizations and outreach, transportation agencies, women's center, respite care, dental, WIC, CHDP, transportation, medical specialist, domestic violence unit, and family planning.

The obstetrician will create and maintain a medical record, utilizing the ACOG or Problem-Oriented Patient Risk Assessment System (POPRAS) forms. The medical record must include, at minimum: initial and periodic laboratory tests; medical risk assessment; a treatment plan or proposed interventions; methods and time frames; objectives and outcomes; proposed referrals; obstetric reassessment flow sheets; staff responsibility; date of pregnancy; follow-up visits; parameters assessed (maternal and fetal); special tests done as indicated by developing risk status; additional counseling; nutrition (WIC); childbirth counseling; psychosocial services and needs assessment. In addition, the HIV testing form or its equivalent (see the Confidential HIV Testing Section) must be documented in the Member's record. The Los Angeles County Department of Health Services CPSP assessment form must also be used unless CPSP services, once explained, are refused by the Member.

If for any reason an obstetrician does not wish to use the ACOG or POPRAS forms, he/she must submit the proposed forms to CHP's Chief Medical Officer for review and approval.

PREGNANCY AND POSTPARTUM SERVICES (continued)

Genetic Screening, Counseling and Referral

Pregnant CHP Members will be provided genetic screening, counseling, and referral as needed. The counseling is obligatory before antenatal diagnostic studies are performed. Key components of genetic counseling are: diagnosis, communication, and options. The PCP is to be contacted by the obstetric provider when there is a need for medical geneticist assessment and counseling. The PCP authorizes or requests authorization for requisite referrals.

SEXUALLY TRANSMITTED DISEASES

Upon request or indication through assessment, CHP PCP's will provide confidential Sexually Transmitted Disease (STD) screening and testing, diagnosis, treatment, follow-up, counseling, education and preventive care. Members should be encouraged, but not required, to obtain these services from their PCPs, when indicated. State and federal law prohibits requiring that a Member receive authorization prior to accessing STD services. As such, these Members, including minors aged 12 and older without parental consent, have the right to access these services with any provider within or outside of CHP's network of providers.

STD screening may also be obtained from the County of Los Angeles Sexually Transmitted Disease Program listed above at (213) 744-3070 (for referrals) or call the STD/HIV Hotline at (800) 758-0880.

Members are informed of their rights to seek confidential STD testing and counseling services both within and outside of the CHP network. Information sources include, but may not be limited to, Member Handbooks, newsletters, brochures and health education materials.

Clinical Guidelines

PCPs will treat STDs, as appropriate, and will serve as Members Case Manager for STD services. Guidelines for the screening, evaluation, diagnosis and treatment will be consistent with the latest STD Guidelines recommended by the U.S. Public Health Services (USPHS) as published in the most recent Morbidity and Mortality Weekly Report (MMWR). These guidelines are available on the following website: **http://www.cdc.gov/STD/treatment/rr5106.pdf.**

PCPs are to follow recommendations of the Los Angeles County STD Control Program to provide education and guidelines on STD prevention and treatment to CHP Members. Health providers may access the County of Los Angeles Sexually Transmitted Disease Program website for more information on California STD Treatment Guidelines for Adults and Adolescents at: **http://www.lapublichealth.org/std/providers.htm**

Confidentiality

Provider Groups and PCPs must implement procedures to ensure confidentiality in the provision of STD services. These procedures must include, but not be limited to:

The manner in which medical records are safeguarded

SEXUALLY TRANSMITTED DISEASES (continued)

How employees are to protect medical information
Under what conditions information can be shared

STD Reporting

State law mandates that specified STDs (i.e., chancroids, chlamydia, gonorrhea, nonspecific urethritis, pelvic inflammatory disease & syphilis) be reported to local Health Officers. Providers are to report diagnosed STD cases to local Health Officers using the procedures of the County of Los Angeles, the City of Long Beach, and the City of Pasadena local Health Departments. These incorporate the Case Definitions for Reportable STDs (January 1998) and the Confidential Morbidity Report form. All diagnosed Members who fail to complete treatment must also be reported. The L.A. County STD Program can be reached at:

Sexually Transmitted Disease Program
2615 S. Grand, Room 500
Los Angeles, CA 90007
(213) 744-3251 (Call this number for Confidential STD Morbidity Report Cards)
The CMR STD Report Form may be obtained from the following website:
www.publichealth.org/std

For reporting cases of communicable disease of patients residing in the cities of Long Beach or Pasadena, providers should contact the local City Health Departments at:

City of Long Beach	(562) 570-4369
City of Pasadena	(626) 744-6128

SEXUALLY TRANSMITTED DISEASES (continued)

PUBLIC HEALTH CENTERS WHICH PROVIDE STD SERVICES

Health Center	Address	Phone
Antelope Valley	335 East Avenue K-6, Lancaster	(661) 723-4511
Yvonne Burke	2509 Pico Boulevard, Santa Monica	(310) 998-3203
Central	241 N. Figueroa, Los Angeles	(213) 240-8225
Glendale	501 N. Glendale Avenue, Glendale	(818) 500-5762
Hollywood-Wilshire	5205 Melrose Avenue, Los Angeles	(323) 769-7932
Monrovia	330 W. Maple Avenue, Monrovia	(626) 256-1600
Pacoima	13300 Van Nuys Boulevard, Pacoima	(818) 896-1903
Pomona	750 S. Park Avenue, Pomona	(909) 868-0235
South	1522 E. 102nd Street, Los Angeles	(323) 563-4112
Ruth Temple	3834 S. Western Avenue, Los Angeles	(323) 730-3507
Torrance	711 West Del Amo Blvd., Torrance	(310) 354-2300
Curtis Tucker	123 W. Manchester Blvd., Inglewood	(310) 419-5362
Whittier	7643 S. Painter Avenue, Whittier	(562) 464-5350

SPECIALTY MENTAL HEALTH SERVICES

All inpatient mental health and outpatient specialty mental health services are carved out of and excluded from CHP's responsibilities, and will be provided to CHP Members by Los Angeles County Department of Mental Health (LAC/DMH). Psychotherapeutic drugs on the CHP Medi-Cal Formulary and ordered by the PCP (excluding the Carve-Out drugs), are covered by CHP.

CHP informs Members of mental health services through the Member Handbook and distribution of mental health brochures in the PCP's office.

Specialty Mental Health Services

Specialty mental health services are mental health services provided by a psychiatrist, a psychologist, or a Licensed Clinical Social Worker (LCSW).

Role of Primary Care Physicians

The PCP is responsible for:

- Providing basic outpatient mental health services, within their scope of practice and training.
- Ensuring appropriate referral of Members to and coordination of care with LAC/DMH for assessment and treatment of mental health conditions, outside the scope of their practice and training.
- Identification and referral of Members in need of outpatient specialty or inpatient mental health services.
- Basic case management and coordination of Member's service needs including their mental health services needs.
- Coordinating the exchange of confidential psychiatric and medical records with the DMH provider in accordance with applicable state and federal laws and regulations.

Provider Groups' are responsible for:

- Covering and paying for all medically necessary emergency and non-emergency medical transportation services to an acute care and/or psychiatric facility except when the purpose of the medical transportation is to transport the Member from a psychiatric inpatient hospital to another facility to which the patient is being transported will result in lower costs to DMH.

SPECIALTY MENTAL HEALTH SERVICES (continued)

All medically necessary treatment provided at an acute inpatient facility, including payment of the History and Physical which is required within 24-hours of admission.

Covering and paying for medically necessary Laboratory, Radiological and Radioisotope services.

Referral

PCP's will utilize the toll free 24-hour, 7-days, 800-854-7771 ACCESS number to refer Members to the Department of Mental Health.

Members may access mental health services by self-referral, family referral or by the PCP or other specialty provider.

Psychotherapeutic Drugs

CHP is responsible for payment of CHP Formulary psychotherapeutic drugs (excluding Carve-Out drugs) and laboratory tests prescribed/ordered by specialty mental health providers. Please see Exhibit S for a list of Carve-Out drugs.

TUBERCULOSIS

Tuberculosis (TB) screening, diagnosis, and treatment are the responsibility of the PCP. Providers are responsible for targeted TB testing of individuals at high-risk for TB infection and for the provision of preventive therapy for those who are eligible. Early identification and containment of active TB disease is essential when found either through targeted testing or the symptomatic presentation of a client. The Los Angeles County Department of Health Services Tuberculosis Control Program, Policy Guidelines and Treatment Guidelines are available at the following website:
http://www.lapublichealth.org/tb

PCPs partner with the Los Angeles County Department of Health Services (DHS) in the mission of eliminating TB. Early identification and containment of active TB disease is essential when found though either targeted testing or the symptomatic presentation of a client.

In Los Angeles County, the recommended treatment model for all TB suspect cases is Directly Observed Therapy (DOT).

Directly Observed Therapy

Directly Observed Therapy (DOT) is the standard of care for all TB suspect cases. Special attention must be given under the following circumstances:

- DOT referral for patients with demonstrated multiple drug resistance (defined as resistance to INH and Rifampin); patients whose treatment has failed or who have relapsed after completing a prior regimen; children and adolescents, and individuals who have demonstrated noncompliance (who have failed to keep office appointments).

- DOT consideration for substance abusers, persons with mental illnesses; the elderly; persons with unmet housing needs; and persons with language and/or cultural barriers.

DOT is only provided by Los Angeles County Public Health staff, therefore the treatment and management of the CHP patient should be referred to the local Public Health clinic through the TB Control Program at the time of reporting.

The district Public Health Nurse (PHN) will act as the Case Manager for the tuberculosis suspect/case while the CHP PCP will continue as the patient's Plan coordinator. Timely notification that the patient is enrolled in a Medi-Cal Managed Care Plan will facilitate communication and co-management of the patient between the PCP and the TB clinician.

TUBERCULOSIS (continued)

Once the Member is in the DOT program, DOT provides for medications and administration.

Reporting

Refer to Exhibit P, "Confidential Morbidity Report of TB Suspects & Cases form and explanation.

All TB suspects/cases shall be reported to TB control within **one** working day.

Also reportable to TB Control, for source case finding, are children **age 3 years** and under who have a positive TB skin test and a normal chest x-ray. TB Confidentiality Morbidity Report forms may be obtained by calling TB Control:

L.A. County Tuberculosis Control Program
2615 S. Grand, Room 507
Los Angeles, CA 90007
(213) 744-6160 (phone); (213) 749-0926 (fax)
(Faxable TB Confidential Morbidity Report Forms may be obtained by calling the above number or accessing the website at: **http://www.lapublichealth.org/tb**)

To report cases of communicable disease for patients residing in the cities of Long Beach or Pasadena, contact the local City Health Departments at (562) 570-4000 ext. 4315 and (626) 744-6128, respectively.

Contact Investigation

Contact investigation is a mandated Public Health activity. The PCP may provide a more timely evaluation of a Member's TB contacts and share the results with Public Health. Communication with the district PHN will assist in identifying those contacts in need of assessment.

Patient Education

CHP will work with the Los Angeles County Department of Health Services TB Control Program to develop and disseminate educational materials and programs to TB patients, family Members, and those undergoing preventive therapy. The elements of the program will include:

TUBERCULOSIS (continued)

- Contact screening,
- Prevention of household spread, and
- Compliance with treatment and follow-up

Infection Control

Inpatient and ambulatory health care facilities are required to follow guidelines developed in accordance with Los Angeles County Department of Health Services' TB Control Program's policies for prompt detection and isolation of suspected TB cases.

Infection control procedures should be implemented to avoid the spread of TB from infectious individuals. The main goal of the patient infection control program is to detect TB disease early and to isolate and treat promptly persons who have TB. Persons who are suspected of having pulmonary or laryngeal TB should be considered infectious if they are coughing, undergoing cough-inducing or aerosol-generating procedures, or have sputum smears which test positive for acid-fast bacilli, and they are not receiving therapy, have just started therapy, or have a poor bacteriological response to therapy.

CHP providers are to follow their own infection control policies as well as these:

I. Administrative Controls

Essential for a TB Control Plan is:

- The identification of one person to be accountable for TB control concerns

- A risk assess for TB must be conducted for the facility and staff by department, occupation, and work assignment.

A. Containment

1) Identification of symptomatic person
   - X All staff must be proactive to notice a person who is coughing, give the person tissues to cover their cough, and notify the triage nurse

2) Notification
   - X A triage nurse must be identified for referrals at any time during open hours

TUBERCULOSIS (continued)

3) Triage of Persons with Pulmonary Symptoms

- Coughing patient must be moved as soon as possible to safe exam room
- Patient must wear a surgical mask or the health care worker (HCW) must wear a National Institute of Occupational Safety and Health (NIOSH) certified respirator during the evaluation
- The triage nurse should use the Algorithm for TB Suspect Triage to determine the acuity of the patient and plan of action
- Prompt medical evaluation of persons with symptoms suggestive of TB
- There must be standing orders for STAT chest x-rays, sputum exams, and skin testing
- If unable to perform diagnostic tests and/or isolate patients, there must be an appropriate referral resource and plan for referral

B. Employee Surveillance

1) Required Exam

- Baseline Purified Protein Derivative (PPD) (Mantoux technique) unless written documentation of previous positive PPD
- A history of Bacille Calmette-Guerin (BCG) vaccination is **not** a contraindication for a TB skin test
- TB Symptom Review
- Chest X-ray if PPD is positive
- Referral for preventive therapy for all employees who meet TB Control guidelines
  - Persons of all ages with medical risk factors
  - All reactors under age 35
- Exclusion of employees with suspect pulmonary TB until physician clearance is obtained

2) Recommended - Two Step Skin Testing

- Two step skin testing reduces the likelihood that a boosted skin test reaction will be interpreted as a recent infection
- Procedure
  - If the reaction to the first skin test is negative (less than 10mm), a second test should be given one to four weeks later
  - If the reaction to the second skin test is positive ≥ 10mm, the person should be considered TB infected and a chest x-ray is indicated

TUBERCULOSIS (continued)

3) X-Ray Screening

- Chest x-ray alone without a skin test is not acceptable as a routine TB screening method even if the x-ray is normal.

4) Repeat Exam

- Determine frequency of the PPD testing by non-reactors by risk assessment (occupation and work area)
  - All persons at risk for prolonged exposure to an unmasked coughing, suspected or confirmed smear positive TB patient, should have PPD and symptom review every six months (or more if skin test conversions are occurring); i.e., Chest Clinic health care workers; triage and counseling doctors
- All documented PPD reactors must have:
  - Annual TB symptom assessment
  - Chest x-ray if symptoms are present
  - If high risk medical or social factors (such as HIV+, immuno-compromised, abnormal chest x-ray) exist, employees must have an annual chest x-ray unless an adequate course of preventive has been completed

5) Documentation, Data Collection, and Evaluation

- PPD conversions rate by work area and/or occupational group to be evaluated monthly
- All PPD converters must be entered on the California Occupational Safety Health Appeals Board (Cal/OSHA) 2000 Log

C. Employee Education

TB prevention training must be provided to all employees annually and should include the following information:

- Mode of TB transmission, symptoms, and treatment, the differences between infection and disease, screening and preventive therapy
- Individuals at increased risk for TB, especially those HIV+
- Connection between TB and HIV
- Personal protection education and training for fit and usage of equipment for assigned staff
- Instruction to report chronic illness to supervisor

TUBERCULOSIS (continued)

II. Engineering Controls

Effective Ventilation

- The ventilation system must be properly cleaned, maintained and functional
- Air exchanges, a minimum of 6-10\hour and negative pressure in any area where infectious TB suspects or cases are held and\or examined
- High risk procedures, i.e., sputum induction, need either 12 air changes an hour (ACH) and negative pressure or 6-10 ACH, negative pressure and local exhaust
- Air should be exhausted to the outside and not recirculated within the facility. If air is recirculated, it must pass through a high efficiency particulate air (HEPA) filter
- All respiratory precaution areas must be identified and posted when in use as *Atmospheric Isolation* or *High Risk Atmospheric Procedure*

III. Personal Protection Controls

A. Symptomatic patient: (TB suspect or infectious patient) must wear a surgical mask while:
- In a room other than an atmospheric isolation room
- Being transported within the health facility or by car

B. Staff: Must wear a NIOSH-approved 95N or High Efficiency Particulate Air (HEPA) respirator when:
- In a room with an infectious patient who is undergoing a high-risk procedure (sputum induction, bronchoscopy)
- Occupying the room with an unmasked coughing, suspected or confirmed smear positive TB patient
- Entering a room within one hour after the room was occupied by an unmasked TB infectious suspect or case
- When transporting an unmasked infectious patient in an enclosed vehicle
- Changing filters in the HEPA filtration machine
- Alternatives to personal respirators must be available for persons who cannot be fit tested (e.g., men with beards). Alternatives include Powered Air Purifying Respirators (PAPRs) or reassignment of the employee.

C. Respirator Fit Testing
- Staff selected to wear respirators must be fit tested and receive instruction on use and care.
- Each facility must have a written Respirator Protection Program.
- Information and resources about instituting a Respirator Protection Program is available through TB Control at (213) 744-6160.

VISION SERVICES

Members are eligible to receive vision care services, including the provision of examinations and eyewear. Vision care is covered in the capitation payments to the CHP Provider Groups.

Procedures

Members seeking eye care services and/or prescription for eyeglasses need to obtain authorization from their PCP/Provider Group for a referral to a vision provider. Any vision services to be performed must be indicated on the Referral Form, along with an authorization number. As a covered benefit, Members may obtain one pair of prescription glasses every two years, unless the Member's prescription has changed and replacement is required. Additional services and lenses are to be provided based on medical necessity.

Lost, broken or significantly damaged eye appliances may not be replaced unless the Member supplies the PCP with a signed statement outlining the circumstances of the loss or destruction and the steps taken to recover the lost item, and certifying that the loss, breakage or damage was beyond the Member's control. PCP's shall not be held responsible for inaccurate statements provided by Members.

The vision care provider is to verify the Member's eligibility prior to scheduling an appointment. If a vision services provider feels the Member should be referred to an ophthalmologist or other physician, he/she is to call the Member's PCP for a telephone referral authorization. This is necessary to ensure the PCP is aware of any potential conditions that may be related to the general health of the Member (such as diabetes).

Note: The Prison Industry Authority (PIA) must fabricate all lenses for CHP Members. The PIA for Los Angeles County Medi-Cal beneficiaries (including CHP Members) is: PIA Optical Lab, Richard J. Donovan Correctional Facility at Rock Mountain, 480 Alta Road, San Diego, CA, (800) 722-1226. If you have any questions about this program, you may call PIA at (916) 358-1738.

WOMEN, INFANTS, AND CHILDREN (WIC) NUTRITIONAL SERVICES

All CHP Members who are pregnant, breast-feeding, and postpartum women, infants and children will be assessed for WIC supplemental food services eligibility and need, and if appropriate, referred to the local Health Department's WIC Program.

Screening of Nutritional Needs and WIC Eligibility Identification and Referral

PCPs are to identify pregnant, breast-feeding, or postpartum women, and children under the age of five who are eligible for WIC supplemental food services.

PCPs are to perform a nutritional assessment as well as hemoglobin or hematocrit laboratory tests, assess for history of frequent illness or a general poor state of health. In the case of pregnant women, PCPs may refer Members to nutritionists for further assessment.

The PCP or nutritionist is to initiate the referral to WIC, if appropriate. Members may also self refer to WIC centers. Hemoglobin and hematocrit test results, height/length, weight, and EDC reported on a CHDP form PM160 for children, or the CPSP assessment tool, are to be provided to the WIC program with all referrals. The PCP must document the referral in the Member's medical record. If requested by the WIC program, the PCP is to provide subsequent biochemical test results or other tests.

The PCP maintains the role of the overall case manager for the Member which includes assuring appropriate referrals for Members needing WIC services and providing routine preventive and other necessary care.

The WIC program will schedule an appointment with the Member to determine eligibility within 15 days of the initial referral contact, unless the Member is determined to be at high risk, in which case she/he will be seen immediately. At this time, the Member's nutritional risk will be evaluated based on physical, biochemical, and other clinical information submitted with the PCP's referral.

A complete dietary assessment will be done at the time of WIC program enrollment and during recertification. (The CPSP dietary assessment information will satisfy the WIC program dietary assessment requirements at each trimester visit for pregnant women. A copy should be given to the Member with instructions to carry the nutritional assessment with her to the WIC office.)

WOMEN, INFANTS, AND CHILDREN (WIC) NUTRITIONAL SERVICES (continued)

Formulas Provided by WIC

- Enfamil with Iron
- ProSobee

Formulas Not Provided by WIC

- Therapeutic formulas
  - Pregestimil
  - Nutramigen
  - Alimentum
  - Neocate
- Premature formulas
  - Similac Special Care 24
  - Enfamil 22
  - NeoSure
- Special cow-milk based formulas:
  - Enfamil AR
  - Similac PM/60/40

Provider Groups are responsible for covering and paying for medically necessary therapeutic formulas.

UTILIZATION MANAGEMENT - SECTION 8

UTILIZATION MANAGEMENT OVERVIEW

The objectives of Utilization Management (UM) are to ensure and facilitate the provision of appropriate medical care to CHP Members and monitor and support activities that continually improve the quality of medical care.

CHP retains UM responsibility for out of area (outside of L.A. County) emergency and inpatient services, first-level appeals, and retrospective review of claims for CHP DHS Facilities, Primary Care Contractors, and Provider Groups who have not been approved for claims adjudication.

CHP delegates UM functions, excluding appeals, to Full Risk Provider Groups. CHP retains responsibility for oversight of delegated UM functions.

Provider Groups are to perform delegated UM functions that are consistent with CHP standards, as set forth in this manual, and the CHP contract, and any other CHP policies, procedures, and directives that may be issued.

UM Delegation Standards

Provider Groups approved for UM delegation must adhere to the standards set forth below:

The delegated entity must have a written UM Program which includes, but is not limited to, the following elements:

- Documented goals and objectives and describe the organizational structure and staffing for performing the program functions,
- Policies and procedures to evaluate medical necessity and/or nationally recognized and locally approved criteria, information sources, and a process to review and approve services,
- Identification and correction of areas of over-utilization and under-utilization of services,
- A mechanism to periodically, at least annually, update the UM Program, guidelines, protocols, policies, and procedures,
- Documented evidence of approval of the UM Program by the Governing Body.

UTILIZATION MANAGEMENT (continued)

A Medical Director who is licensed as a physician to practice medicine in California and who provides oversight of the UM Program. The Medical Director is to have a defined scope of responsibilities.

A Utilization Management committee which meets at least quarterly to review utilization issues and determine improvement where indicated. CHP representatives may attend the committee meeting, upon advance request.

The minutes of the Utilization Management committee must be made available upon request to CHP.

CHP representative staff must be permitted reasonable access to Provider Groups' utilization management files, minutes and records of the UM Committee meetings, for purpose of auditing utilization management activities.

Pre-authorization, concurrent, and retrospective (if delegated) review decision processes that are consistent with the following CHP standards:

Are supervised by an appropriately qualified professional.
A physician conducts a medical review on all denials, modifications, deferrals related to medical necessity or benefits.
Board-certified physician specialists are used as consultants to assist in determining medical necessity. Documentation is maintained to support their decision.

Non-physician UM staff with any level of utilization decision-making authority will be clinical nurses licensed to practice in California. Staff ratios are to be appropriate to the level of delegated UM responsibilities.

Written decision protocols are based on reasonable and appropriate medical standards. Written documentation of the application of decision protocols must contain the elements below.

Criteria are clearly documented and communicated to participating physicians and available to the physician and Member upon request.
A mechanism in place for checking the consistency of the application of criteria across reviewers (at least annually).
A mechanism in place for updating review criteria periodically (at least annually).

UTILIZATION MANAGEMENT (continued)

Criteria to determine the appropriateness of medical services must be consistent with those adopted by CHP (Milliman Care Guidelines and/or Interqual Intensity of Service and Severity of Illness). Current medical literature and community practice standards may be utilized as a source of reference in making UM decisions.

Efforts are made and documented to obtain pertinent clinical information during the UM decision-making process, including the treating physician.

A system is maintained to track authorizations (approvals, denials, modifications, deferrals) and encounters. The system captures appropriate data elements.

Reporting Requirements

UM data must be sent to CHP within the specified time frame and must be in an appropriate format as requested by CHP's UM and Managed Care Information Services departments for trending and reporting compliance with State and Federal regulatory requirements and CHP requirements.

Oversight Monitoring

CHP will monitor and oversee the delegated UM activities of Provider Groups to ensure ongoing compliance with State, Federal, and CHP requirements.

CHP UM staff will monitor data submitted by Provider Groups on an ongoing basis. Corrective action plans will be requested and monitored whenever data analysis, report and document review indicate less than full compliance with the standards for UM delegation.

Annual site visits to Provider Groups will be conducted by CHP Quality Management Department and will include a review of UM delegated functions utilizing CHP's standardized audit tool.

Coordination of Medically Necessary Services

The Primary Care Physician is to serve as the medical case manager and gatekeeper. As such, the Primary Care Physician is responsible for making referrals and coordinating all medically necessary services a Member needs.

UTILIZATION MANAGEMENT (continued)

Outpatient Referral

If the Member requires treatment or examination outside of the standard primary care services, the Primary Care Physician is responsible for:

Initiating referral to the appropriate specialist or facility and obtaining authorization, when needed.

Documenting the referral in the Member's medical records and attach any authorization paperwork.

Receiving reports and feedback from the referral provider regarding the consultation and treatment. (A written report must be sent to the Primary Care Physician by the treating provider or facility the Member was referred to.)

Discussing the results of the referral and any plans for further treatment, if needed and care coordination with the Member.

Referrals must be tracked by the Primary Care Physician's office and the authorizing Provider Group for follow-up through a tickler file, log or computerized tracking system. The log or tracking mechanism should include the following for each referral:

Member name and identification number,
Diagnosis,
Date of authorization request,
Date of authorization,
Date of appointment, and
Date consult report received. (Physicians must initial and date review of report).

Hospital Inpatient Care

The Primary Care Physician is responsible for obtaining required pre-authorization for inpatient care from the Provider Group.

Inpatient Concurrent Review

Inpatient concurrent review will be conducted by the delegated Provider Group as follows:

UTILIZATION MANAGEMENT (continued)

Concurrent review will begin within one day of admission and include an assessment of appropriateness of level of acute care using accepted criteria.

Concurrent review will be conducted daily or periodically on or before dates assigned at the end of the initial and each subsequent review. These reviews will be conducted utilizing accepted guidelines for acute level of care, such as intensity of service, severity of illness criteria or Milliman Guidelines.

Concurrent quality issues noted during utilization review will be documented and reported to the Provider Groups' Medical Director and Quality Management Department upon discovery.

Utilization review concurrent focus will be proactive and UM/Case Management levels of focus will be employed as appropriate.

Discharge Planning

Provider Groups UM staff will begin discharge planning within 24 hours of admission and facilitate involvement of a multidisciplinary team of physicians, nursing, social work, and others, as appropriate.

Patient and family intervention will occur throughout the stay to assure discharge plans are in place and appropriate for each Member. Discharge plans will consider the disease process, treatment requirements, the family situation, and available benefits and community resources.

Average length-of-stay guidelines will be used for discharge planning purposes.

Questionable continued stay plans are to be discussed with the attending physician and then reviewed by the Provider Group's UM physician for further discussion with the attending physician.

Prior Authorization of Services

The delegation of UM affords broad authority for Provider Groups to establish prior authorization requirements. The parameters set forth below must be followed by Provider Groups in developing prior authorization requirements:

Services That Do Not Require Prior Authorization:

Preventive health services, including immunizations,

UTILIZATION MANAGEMENT (continued)

Annual well women care,
Sensitive and confidential services and treatments (including but not limited to services relating to sexual assault, pregnancy and pregnancy related services, family planning, abortion/pregnancy termination, sexually transmitted diseases, drug and alcohol abuse, HIV testing and treatment, and outpatient mental health counseling and treatment),
Family Planning Services including outpatient abortions through family planning providers,
Sexually Transmitted Disease services both within and outside of the provider network,
Confidential HIV testing including access to confidential HIV counseling and testing services both through the network and through the out-of-network local health department and family planning providers,
Basic prenatal care, including OB/GYN in-network referrals and consults,
Minors do not require parental consent to receive confidential services, such as Family Planning, diagnosis and treatment of STD's, abortion, medical care related to sexual assault or rape, and emergency medical services (if parent/guardian is unavailable), and
Emergency Services (medical screening and stabilization).

Services That May Require Prior Authorization

The services listed below should require prior authorization:

Transplant evaluation,
Hospital admission (non-emergent),
Most elective surgical procedures (inpatient or outpatient),
Second opinions,
Durable Medical Equipment,
Home health,
OT, PT, speech therapy,
Hospice, and
Specialty Care

Standing Referral to Specialist

Provider Groups must have established procedures in which 1) a Primary Care Physician (PCP) may request a "standing referral• to a specialist for a Plan Member who has a condition or disease (including HIV or AIDS) that requires specialized care over a prolonged period of time and that may be life-threatening, degenerative, or

UTILIZATION MANAGEMENT (continued)

disabling**.** Alternatively 2) a specialist may act as the primary physician coordinating care for a Member with a chronic condition.

The Provider Group shall establish procedures for a Member to receive a standing referral to a specialist (or a specialty care center) with demonstrated expertise in treating specific conditions or diseases involving complicated treatment regimens that require on-going monitoring of the patient's adherence to the regimen.

Standing referral means a referral by a PCP to a specialist for more than one visit, as indicated in the treatment plan, if any, without the PCP having to provide a specific referral for each visit.

Specialty Care Center means a center that is accredited or designed by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the life-threatening disease or condition for which it is accredited or designated.

Providers who have expertise in treating a condition or disease are those which meet, but not limited to, the following requirements:

- Board certified or board eligible
- Satisfactory completion of a defined course of graduate medical education and appropriate certification in the specialty area
- Possess special knowledge, skill and professional capability in the area of specialty

The procedures for standing referrals shall include but are not limited to:

- Establishment of the medical conditions and/or diseases, including HIV or AIDS, and specialties to which this procedure will be applied;
- Requirement that a decision whether to grant a standing referral be made within three business days of a request;
- Requirement that the time frame to schedule a referral appointment to a specialist be within four business days of a request;
- Establishment of the circumstances in which a specialist may serve as a Member's main care coordinator; and
- Encouragement for PCPs and specialists to develop treatment plans for patients with chronic diseases or conditions who are under their care.

UTILIZATION MANAGEMENT (continued)

Authorization, Denial, Modification, or Deferral and Notification

Provider Groups with delegated UM functions must adhere to the following:

Decision Timeframes

Authorize, Deny, Modify Prior Authorization Requests as follows:

Non-Urgent (routine) request within **five (5) working days** of receiving all necessary information.
Urgent request within **twenty four (24) hours** of receiving all necessary information.
Emergency post-stabilization services requests within 30 minutes of verbal request.

Document or date stamp receipt of referral request.

Notification Timeframes

For non-urgent requests, notify provider (via phone or fax) of the decision within **one (1) working day** of making decision.
For urgent requests, notify provider (via phone or fax) of the decision within **one (1) calendar day** of making decision.
Send Notice of Action Letter to Member and provider within **two (2) business days** of rendering decision. The Notice of Action Letter must be sent in the Members' preferred language.
The Notice of Action Letter, referral request form, and supporting medical records reviewed as a basis in rendering the decision must be sent to CHP Utilization Management Department within **one (1) business day** of sending to Member and provider. Send via fax to: (626) 299-7261.

Deferral / Pended / Delay of Service

Send deferral letter to Member and provider if the decision can not be made within the required timeframe. The deferral letter must also be sent via fax to the CHP Utilization Management Department within **one (1) business day** of sending to Member and provider.

The deferral letter must indicate the reason why the decision could not be made within the required timeframe and the anticipated date (not to exceed 30 days) on which a decision may be rendered. The following are the only

UTILIZATION MANAGEMENT (continued)

reasons why the decision may be deferred:

Lack of receipt of all the information needed to make a decision,
Review process requires consultation by an expert reviewer, and
An additional examination or test needs to be performed.

If the requested information is not received within the specified timeframe, deny the request based upon the review of information initially received. The notice of action letter should **not** cite that the reason for the decision is based upon "lack of information received", rather, it should cite, "based upon the information received".

Physician Reviewer

Only physicians may make denial, modification, deferral decisions that are related to medical necessity or benefits.

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The physician reviewer's decision, review date, and signature must be clearly documented. Initials are not acceptable.

Medical Information

Sufficient medical information necessary to render a decision must be obtained prior to making a decision.

All referral requests should contain pertinent medical records. Request that the provider submit additional medical records necessary to justify the referral request.

Reason for Decision and Criteria Source

The documentation of reason for the decision to deny or modify must include:

A clear explanation of the specific reason for the decision,
Description of the specific criteria or guideline used (such as Milliman, medical literature, and evidence of coverage benefits),
The specific medical reason for any decision relating to medical necessity and, an offer of alternative treatment (e.g. see your PCP for further treatment options)

UTILIZATION MANAGEMENT (continued)

Availability of Physician Reviewer

The Notice of Action Letter to the Member must include language that the requesting provider has been informed of the decision and given the opportunity to further discuss with the physician reviewer.

The Notice of Action Letter or facsimile to the provider must include the name of the physician reviewer, telephone number, and language that the physician reviewer is available to discuss the decision with the provider.

Appeal Process

The following must be referenced in the appeal process:

How to dispute the review determination
Standard Appeal Process
Expedited /72 hour Appeal Process
State Fair Hearing
Ombudsman
Department of Managed Health Care Complaint Process (mandated language)

Notice of Action Letter

Provider Groups are required to use the CHP Notice of Action Template Letter (see Exhibit T).

Second Medical Opinion

At the request of a Member or a participating or contracting provider who is treating a Member, Provider Groups must provide or authorize a second medical opinion by an appropriately qualified health care professional whenever any of the following occurs:

If the Member questions the reasonableness or necessity of recommended surgical procedures,

If the Member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition,

UTILIZATION MANAGEMENT (continued)

If the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating provider is unable to diagnose the condition, and the Member requests an additional diagnosis,

If the treatment plan in progress is not improving the medical condition of the Member within an appropriate period of time given the diagnosis and plan of care, and the Member requests a second medical opinion regarding the diagnosis or continuance of the treatment.

If the Member has attempted to follow the plan of care or consulted with the initial provider regarding serious concerns about the diagnosis or plan of care.

An appropriately qualified health care professional is a primary care physician, specialist, or other licensed health care provider who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second medical opinion.

The request for a second medical opinion shall be reviewed and determined by each provider/Provider Group=s Medical Director or physician designee who will make an approval or denial decision based on the Member=s condition, above-mentioned criteria and medical judgment. Provider/Provider Groups shall follow the time frame in reviewing and communicating the decision to the Member in accordance with CHP turn-around-timeframes.

If the Member=s condition is such that the Member faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or lack of timeliness that would be detrimental to the Member=s ability to regain maximum function, a second medical opinion must be authorized or denied in a timely fashion appropriate for the nature of the Members condition, not to exceed 72 hours from the time of receipt, whenever possible.

If a provider/Provider Group approves a request for a second medical opinion about care from his or her primary care physician, the second medical opinion shall be provided by an appropriately qualified health care professional of the Member=s choice within the same Provider Group.

If a provider/Provider Group approves a request for a second medical opinion about care from a specialist, the second medical opinion shall be provided by any provider of the Member=s choice from any Provider Group within the Plan. If the specialist is not

UTILIZATION MANAGEMENT (continued)

within the same Provider Group, the Provider Group shall incur the cost or negotiate the fee arrangements of that second opinion.

In approving a second medical opinion either inside or outside of the Plan's network, the ability of the Member to travel to the provider office should be taken into consideration.

If additional second medical opinions are denied by the Provider Group, subsequent second medical opinions not within the original Provider Group shall be the responsibility of the Member.

In the event that there is no participating provider within the network who meets the standard as an appropriately qualified health care professional, then the provider/Provider Group shall authorize a second medical opinion outside of the Plan's provider network. If the specialist is not within the Plan's provider network, the Provider Group shall incur the cost or negotiate the fee arrangements for that second medical opinion.

Physicians/physician specialists who provide a second medical opinion to a CHP Member are required to provide the Member and the primary care provider with a consultation report, including any recommended procedures or tests that the second medical opinion physician/physician specialist believes appropriate. If the provider/Provider Group denies a request for second medical opinion, the provider/Provider Group shall notify the Member in writing of the reason(s) for the denial and inform the Member of the right to file a grievance with the health plan.

Continuity of Care

At the request of Members, network Provider Groups must provide or arrange for the completion of covered services from a terminated provider/hospital or non-participating provider/hospital if the Member has one of the following conditions and was receiving services from the terminated provider/hospital or non-participating provider/hospital at the time of contract termination or at the time a new Member became eligible under CHP. The qualified conditions and the specified time periods are as follows:

- An acute condition, for the duration of the acute condition.
- A serious chronic condition, for the period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, not to exceed 12 months.
- A pregnancy, for the duration of the pregnancy and the immediate postpartum period.
- A terminal illness, for the duration of the terminal illness.

UTILIZATION MANAGEMENT (continued)

Care of new born child whose age is between birth and age 36 months. Completion of covered services shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered Member.

Performance of surgery or other procedure that has been authorized by the Plan, as part of a documented course of treatment that is to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered Member. CHP authorization is not required for the surgery or other procedure that was scheduled within 180 days prior to the effective date of coverage for the newly covered Member.

Upon receipt of a request for continuity of care from a Member, network Provider Groups are required to take the following steps:

Review Member's request and supporting documents to determine whether continuity of care criteria are met. Upon review, reasonable consideration must be given to the potential clinical effect on a Member's treatment caused by a change of provider.

Inform the terminated or non-participating provider/hospital of Member's request, the network Provider Group's reimbursement rate and program requirements.

Offer approved Medi-Cal rates as reimbursement to non-contracted providers pursuant to AB 1286.

Arrange services and issue authorizations according to the network Provider Group's authorization guidelines, including the required timelines which are not to exceed five (5) working days in making a decision for a non-urgent request and 24 hours for urgent request.

If the terminated provider /hospital or non-participating provider/hospital accepts the above-mentioned conditions and rate, document in the Member's file.

Instruct the Member of service date and location.

If the terminated provider/hospital rejects the offer, notify the Member regarding the outcome of the request and instruct the Member to select a new primary care provider or specialist or hospital consistent with the type of covered services to be completed.

UTILIZATION MANAGEMENT (continued)

Definitions:

Acute condition: An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute duration.

Serious chronic condition: A serious chronic condition is a medical condition due to disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the health care service plan in consultation with the enrollee and the terminated provider or nonparticipating provider and consistent with good professional practice. Completion of covered services shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered enrollee.

Terminal illness: A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services shall be provided for the duration of a terminal illness.

QUALITY MANAGEMENT (QM) PROGRAM - SECTION 9

OVERVIEW

Provider Groups must have a QM program in place, which is approved and monitored by the Plan. Provider Groups must submit their QM program description, UM program description, work plan and the annual program evaluation to CHP for review and approval.

The Quality Management Unit /CHP Medical Administration is responsible for overseeing CHP network Provider Groups' clinical/medical programs, which include but are not limited to coordination of care; quality of care; credentialing; peer review; and Utilization Management/Case Management. The oversight function is accomplished through facility site review, annual programmatic review, and ongoing monitoring.

The results of the audits and Corrective Action Plans (CAPs) are reported to the Medical Affairs Committee for review and determination. The audit findings and other quality improvement reports are incorporated into providers' credential files as appropriate.

Network provider/Provider Groups may be terminated for repeatedly failing to meet the standards and requirements set forth in this oversight program.

PROVIDER CREDENTIALING

The CHP providers (primary care, specialists, and mid-level practitioners) are required to be credentialed in accordance with the guidelines set forth in the CHP s Provider Credentialing Protocol, which is based on National Committee for Quality Assurance (NCQA), L.A. Care and JCAHO standards. The intent of this process is to identify any changes in the provider s licensure, certification, sanctions, competence or health status that may affect the provider s ability to perform required services.

The CHP delegates the function of credentialing/recredentialing to its contract Provider Groups and their affiliated hospitals and DHS County facilities. CHP maintains the right to approve/deny participation in the CHP provider network and to terminate or suspend providers in accordance with CHP s policies and procedures and provider contracts. CHP oversees its network Provider Groups credentialing process through pre-delegation (initial) credentialing program review, monitoring, and annual evaluation of the delegate's performance.

The delegated credentialing activities include, but are not limited, to a review of the provider's: credentialing policies and procedures, information collection, primary source

PROVIDER CREDENTIALING (continued)

verification of information, maintenance of credentialing files, review and decision making by a credentialing committee and peer review.

The minimum CHP credentialing requirements include, but are not limited to, the following:

- Completed and signed credentialing policies and procedures to include: program overview, scope of practitioners covered, credentialing/recredentialing criteria and decision making process, confidentiality, practitioner rights during the credentialing process, credentialing committee review, Chief Medical Officer or designee s responsibilities, description of any sub-delegated credentialing/recredentialing activity (if applicable), and standards for the assessment and reassessment for sub-contracted Organizational Providers (if applicable).

- Completed and signed credentialing/recredentialing application that includes statements on: reasons for any inability to perform essential functions of the position with or without accommodation, lack of current chemical dependency/substance abuse (drug use), any loss of license and/or any convictions, any loss or limitations of privileges or disciplinary activity, and attestation to the correctness and completeness of the application.

- Work history (minimum five years) through the application or CV/resume. A written explanation is required for time gaps of more than six months.

- Primary source verification for: License, DEA, clinical privileges, education and training (MDs, DOs, DDSs, DPMs, and allied providers), board certification (if applicable), malpractice insurance, professional liability claims history, National Practitioner Data Bank, Medicare/Medi-Cal sanctions activity verification and follow-up.

- Current professional liability insurance coverage verification at a minimum of $1 million per occurrence/$3 million aggregate per year.

- Signed Medical Services Agreement (contract), if applicable.

- Acceptable performance (in accordance with CHP standards) on the facility site and medical records review.

PROVIDER CREDENTIALING (continued)

- Performance information (in accordance with NCQA standards) related to Member grievances, quality improvement and utilization management activities, medical records review, and facility site review during the recredentialing process.

- Evidence of a credentialing file review and approval by a credentialing committee.

Credentialing/recredentialing information must be available upon request and for review at the time of any audit. DHS Facilities must conduct recredentialing every two years, as required by JAHCO. IPAs/Medical Groups must conduct recredentialing either every two or three years, as defined by the individual IPA's /Medical Group's policies and procedures. The CHP Credentialing Committee will recommend only fully credentialed providers for approval. Final approval will be granted by the CHP Governing Body to participate or continue to participate in the CHP Medi-Cal Program.

Only credentialed providers will be recommended for approval by the CHP Credentialing Committee to participate or continue to participate in the CHP Medi-Cal Program.

A. Facility Site Review (FSR) and/or Programmatic Review (PR)

A FSR or PR is conducted prior to CHP Members' assignment to CHP facilities/providers. CHP requires that every CHP provider pass a triennial FSR. Periodic reviews may be sooner than every three (3) years based upon results of previous audits, corrective actions, etc. L. A. Care performs the FSRs on all CHP sites, including DHS CHP sites for Medi-Cal. The purpose of the FSR is to evaluate each primary care site's compliance with physical plant, medical records and office operations standards established by regulatory agencies. The results of the site survey are shared with the primary care site. Each site is required to conduct all activities necessary to correct any deficiencies identified. CAPs must be formulated and instituted to ensure that the delivery of high quality care is not compromised if a site is found to be in substantial noncompliance with standards and requirements.

The results of the primary care site reviews are also utilized as part of the physician's re-credentialing process.

B. Site Review Process

- Prior to a site review, the primary care site will be contacted in advance by the L.A. Care auditor to schedule the FSR.

- The FSR will involve a survey of the primary care clinic and a review of ten (10) medical records for each CHP primary/specialty as of the site review process. The reviewer has the option to request additional records for review. Sites where documentation of patient care by multiple PCPs occurs in the same record shall be reviewed as a "shared " medical record system. A minimum of 10 records shall be reviewed if two to three PCPs share records, 20 records shall be reviewed for four to six PCPs, and 30 records shall be reviewed for seven or more PCPs.

- The survey will also include reviewing policies and procedures, licenses, miscellaneous documents, etc.

- L. A. Care evaluators will conduct an exit conference at the conclusion of their survey.

- Each provider will receive 2 main scores: combined score (physical plant score plus medical records score) and a critical criteria score.

  The minimum passing score is 80% for the FSR and 80% for the Medical Record Review (MRR). A minimum score of 80% must be achieved to pass the survey. If the score is below 80% for the FSR or MRR, the survey is considered a non-pass.

If a physician's facility site review score falls below 80%, or if a physician fails to comply with any of the site certification critical indicator(s), new enrollment assignments to a physician may be frozen and/or existing Members may be removed and reassigned to another provider. A physician's enrollment may be frozen and/or patients may be removed or reassigned in the following ways: total (all patients), current month's enrollment only, choice only, and by category (e.g., adults, pediatrics, OB, etc.).

L.A. Care requires that a CAP be completed for all deficiencies that are identified during a site certification review. In addition, L.A. Care and/or CHP may also perform a follow-up visit to validate that all necessary corrective activities have been implemented. If an enrollment penalty is imposed on a primary care site, it will remain in effect until the site submits an acceptable CAP. L.A. Care will review all CAPs submitted to determine if they address all deficiencies identified.

Site Review Process (continued)

L.A. Care will notify the Plan of requested CAPs.

If you have any questions or require additional information on the FSR process, contact the Plan Credentialing and Certification Manager at (626) 299-5577.

C. Audits/Reviews (Monitoring of Delegated Medical Functions)

The process is designed to assess the CHP Provider Group's systems and processes in performing delegated functions and to ensure that delegated entities adhere to CHP's standards and regulatory agencies' requirements.

Prior to delegation of any function, and annually thereafter, a due diligence audit for all Provider Groups or affiliated facilities will be conducted by CHP utilizing the National Committee for Quality Assurance (NCQA) guidelines.

The areas of review include: QM, UM, Credentialing, and Medical Compliance (Medical Records, Preventive Health Services, and California Health Plan/Contractor Health Care Regulations).

After the initial delegation, if the network Provider Group continues to meet CHP's delegated standards, the network Provider Group's delegation status will be retained for the following year. If the network Provider Group fails to pass (less than 70%) the delegated medical function/annual audit, the Provider Group will be notified of any deficiencies and a CAP will be requested. The Provider Group has up to 14 days to correct any deficiencies or sooner based on the Chief Medical Officer (CMO)/designee's review. An extension up to and beyond 30 days may be granted based on the CMO/designee's review. In the event that the Provider Group fails to correct the deficiencies within a reasonable timeframe, further actions may include a follow-up focused audit or de-delegation contingent upon the nature and or severity of the deficiencies identified. The delegated status may be withdrawn until the deficiencies are satisfactorily corrected and the Plan's Non-Compliant Provider Sanctions policy may be initiated.

Annual audit reports and CAPs will be presented to Medical Affairs/Peer Review-Credentialing Committee for review and determination.

Site Review Process (continued)

D. On Going Monitoring

In addition to the FSR and the Delegated Medical Functions Annual Review, CHP Provider Groups are monitored regularly through QI, UM, Case Management (CM) reports, programmatic and focus audits. Reports required are as follows:

QM – Health Plan Employer Data Information Set (HEDIS) Studies (annually); UM, authorization activity, case management, referral log, early major organ transplant identification (monthly), TB diagnosis, CPSP, Family Planning, STD, and EPSDT (quarterly).

Also, the contract Provider Groups extends to the Director, and to authorized representatives of the L.A. Care, SDHS, or DMHC, the right to review and monitor Provider Group's programs and procedures, and to inspect its facilities for contractual compliance at any time during normal business hours.

The reports submitted by Provider Groups or generated by the Plan are reviewed and analyzed by the QM and/or UM staff, depending on the type of report. QI, UM, CM findings and recommendations are forwarded to the CHP Chief Medical Officer for review and approval. Reports are aggregated and presented to the QI Committee as indicated for review and recommendations. Provider Groups with identified deficiencies are required to submit CAPs to address areas of deficiency. The time frame and intensity of monitoring are determined based on the severity and areas of deficiency.

Corrective Action Plan

Each significant issue identified through monitoring will require a CAP with clearly stated objectives, time frames, person responsible for the CAP, and relevant supporting documents.

PROVIDER SANCTIONS and APPEALS

CHP providers retain due process protections and may appeal any actions taken by the Plan in regards to their FSR/Annual Review findings.

Written Statement

Due process for providers stipulates that they receive a written statement of actions and adverse determinations defining the following:

- the reasons for any actions or adverse determinations
- the opportunity and method of appeal
- their right to a hearing
- their right to peer review
- the levels for appeals and reconsideration
- confidentiality provisions

Appeals

The first level for appeal by a provider of CHP's actions and adverse determinations is CHP. Appeals not resolved by CHP to the provider's satisfaction may be submitted for review and disposition/resolution determination by L.A. Care.

MAINTENANCE OF MEDICAL RECORDS

PCPs are required to maintain a centralized medical record for each CHP Member that is legible, current, detailed, organized, and permits effective patient care and quality review reflecting all aspects of patient care, including ancillary services. The records must be available to health care practitioners at each encounter and for quality review. The individual medical record must include documentation of care provided within and referred outside of the patient's CHP primary care site.

CHP providers are to follow the minimum medical records general organization, procedures, demographic documentation, and clinical documentation

PCPs are required to maintain policies and procedures which address release of patient information to any internal or external person. The medical record is a legal document and its contents are confidential. Medical records must be stored in a way that makes them inaccessible to patients.

INFECTION CONTROL

CHP providers are to develop and implement their own infection control program which follows Centers for Disease Control of Prevention (CDC) and CAL/OSHA guidelines.

L.A. Care will review the infection control policies and procedures of CHP Provider Groups, as well as their providers, during the FSR process. Reviews may also be prompted by quality studies and Member grievances.

Physician Office

Training and/or communication tools are to be utilized to communicate requirements of the infection control program in the provider office. Infection control compliance is monitored through the FSR mechanism and the analysis of quality studies. Corrective actions shall be undertaken in the instance of noncompliance.

Universal Precautions

The CDC recommendations for precautions related to blood and body fluids for all patient encounters involving direct contact have been established as a response to HIV and Hepatitis B Virus (HBV) modes of transmission. This process is recommended for general use and is referred to as “Universal Precautions.”

The use of Universal Precautions should be so constant as to be considered the routine for preserving the integrity of the infection control process itself. Adoption of these precautions as a standard affords protection to personnel as well as patients cared for within the system at any point of care or facility.

Universal Precautions encompass the following elements:

Involve the use of protective barriers (i.e., gloves, gowns, aprons, masks, or protective eyewear), which can reduce the risk of exposure of healthcare workers’ skin or mucous membranes to potentially infected materials.

Health care workers take precautions to prevent injuries caused by needles, scalpels, and other sharp instruments or devices (i.e., needles should not be not be recapped, purposely bent or broken by hand, removed from disposable syringe or otherwise manipulated by hand. After use, all needles and sharps should be placed in puncture-resistant containers for disposal.

INFECTION CONTROL (continued)

- Hands and other skin surfaces should be washed immediately and thoroughly if contaminated with blood or other body fluids. Hands should be washed immediately after gloves are removed.

- Mouthpieces, resuscitation bags, or other ventilation devices should be available for use.

- Health care workers who have exudative lesions or weeping dermatitis should refrain from direct patient care and from handling patient care equipment until the condition resolves.

- Pregnant health care workers should strictly adhere to precautions to minimize the risk of HIV transmission. Implementation of universal blood and body fluid precautions for all patients eliminates the need for the use of the category of blood and body fluid precautions for patients infected with blood-pathogens. Isolation precautions (e.g., enteric Acid Fast Bacilli 'AFB') should be used as necessary if associated conditions such as infectious diarrhea or tuberculosis are diagnosed or suspected. (CDC Universal Precautions for Prevention of HIV and Other Blood-borne Infections, May 1996, and Public Health Letter, Los Angeles County Department of Health Services). (Further detail regarding application of Universal Precautions follows).

Points of care and facilities range from provider office settings to clinics, hospitals, SNFs and others to cover the range of inpatient and outpatient services over the continuum of care.

All providers and provider policies and procedures are required to comply with CAL/OSHA, SDHS, CDC and any other Federal, State or local agency regulations and standards for the control of infection.

Materials and surfaces that come in contact with patient bodily fluids or blood should also be considered contaminated. Contaminated materials and surfaces must be cleaned and disinfected immediately with solutions that will kill HIV and HBV.

All categories of personnel, visitors and patients should be considered when following or preparing policies and procedures for infection control and cross contamination of infection.

Initial and ongoing (at least annually) staff and provider training and review must be conducted and documented for knowledge of and compliance with infection control policies and procedures.

HEALTH PLAN EMPLOYER DATA AND INFORMATION SET (HEDIS)

I. Overview

HEDIS is a standardized set of performance measures most widely used in the managed care industry to facilitate comparisons of health plan performance. HEDIS is developed and maintained by the National Committee for Quality Assurance (NCQA), which oversees the integrity of the measures, and certifies auditors to verify the appropriateness and accuracy of HEDIS processes among health plan.

For Medi-Cal product line, CHP, as a Plan Partner of L.A.Care, is required to participate in L.A. Care's annual HEDIS process. As a CHP provider, you are required to participate in HEDIS as part of quality improvement activities.

II. Selected HEDIS Measures

A. Medi-Cal Managed Care

CHP is required to participate in generating the following HEDIS measures:

Well-Child Visits 0-15 Months
Well-Child Visits 3-6 Years
Adolescent Well-Care Visits
Childhood Immunizations
Timeliness of prenatal Visits
Postpartum Care
Chlamydia Screening in Women 16-26 Years
Use of Appropriate Medications for People with Asthma

III. Responsibilities of CHP Provider Groups in HEDIS

Regardless of whether you participate in CHP Medi-Cal or HFP or both programs, you are responsible for the following:

Submit accurate and complete encounter data to CHP Information Systems timely. The encounter data you submit to CHP will be used to identify service delivery and to calculate HEDIS measure rates. So the more encounter data CHP has, the fewer chart retrievals you will be required to undertake. Furthermore, many HEDIS measures are based only on encounter data;

Provide copies of CHP Members' medical records upon request from L.A. Care contract schedulers and copy services. The contract scheduler/copy services will provide you with a Member list and necessary identifiers to assist you in retrieving medical records.

PROVIDER RELATIONS - SECTION 10

PROVIDER RELATIONS OVERVIEW

The CHP Provider Relations Unit ensures complete, accurate, and timely information is conveyed to providers regarding issues that affect the Plan s services or its Members.

The CHP Provider Relations Unit accomplishes this mission by:

- Maintaining a Provider Relations Information Line to provide immediate technical assistance during normal business hours;
- Monitoring and coordinating the updating of the CHP Provider Manual
- Coordinating and scheduling new provider orientations, including use of the CHP Provider Manual, to ensure that newly contracted providers are knowledgeable about Plan services and requirements prior to accepting new Members;
- Conducting periodic provider forums;
- Conducting an annual provider satisfaction survey;
- Investigating and responding to provider complaints and grievances, as required;
- Publishing and distributing written information to alert providers of new and upcoming changes in Plan services and requirements, upcoming events, and other items of interest to CHP providers on an as needed basis (at least semiannually) through a combination of utilizing CHP provider newsletters *(Provider News Connection)* via mail and/or Provider Bulletins via fax;
- Providing CHP procedures, forms, and other relevant materials to assist the provider to comply with CHP, L.A. Care, and other regulatory agencies requirements;
- Coordinating training, as needed, for newly contracted and existing providers;
- Developing and distributing operations related policies and procedures; and
- Collecting provider data to generate both the CHP and L.A. Care Provider Directories.

For immediate assistance with specific questions, please contact the Provider Relations Information Line at (626) 299-5599.

PROVIDER RELATIONS (continued)

Provider Database

As part of the application process to become a CHP provider, Provider Relations provides Provider Information Forms (See Exhibit V, Attachments I and III) to collect provider data (PCP, Specialist, and Mid-Level Practitioner) for its provider database. Updated provider information is used to generate the CHP Provider Directory. The provider data requested includes:

Name, degree, office address, gender, CHDP cert.:Y/N, CPSP cert.: Y/N, tax ID #, license #, license exp. date, DEA #, DEA exp. date, Social Security #, appointment telephone, ethnicity, date of birth, employee # (DHS only), languages spoken by provider, languages spoken in office, after hours telephone #, Members services telephone #, fax #, provider s office hours - Monday-Sunday, board cert.: Y/N, practice limitations, provider currently credentialed: Y/N, CHP hospital affiliation (if applicable), hospital address, and hospital telephone #.

If any of the providers have information changes, they should complete a Change of Information Form (Exhibit V, Attachment II) and fax to CHP Provider Relations at (626) 299-7250 or 7251.

Notification of Changes of Information for Provider Directory:

Any change of information for providers listed in the CHP Provider Directory should be reported to the CHP Provider Relations Unit at least ninety (90) days prior to the change by completing a Change of Information Form, as referenced in CHP Policy and Procedure 13.2, Network Updates (Exhibit V.

For changes to the CHP Provider Directory, fax a Change of Information Form to CHP Provider Relations at (626) 299-7250 or 7251.

For changes to the L.A. Care Provider Directory, providers should call the L.A. Care Provider Network Services Line at (866) 522-2736.

PROVIDER CONTRACTING

How to Become a Traditional and Safety Net Provider

All Safety Net providers who meet the credentialing and participating conditions required of other providers for similar services are to be offered contracts.

Traditional and Safety Net providers who do not meet any Plan Partner s minimum credentialing requirements, but who still wish to be a Medi-Cal Managed Care provider through L.A. Care, may be required to attend special training sessions designed or approved by L.A. Care to enable them to correct deficiencies. For more information, contact the L.A. Care Provider Network Services Line at (866) 522-2736.

How to Become a CHP Provider

A provider who is interested in becoming a CHP provider must contact CHP directly. While CHP doesn t contract directly with individual providers, it does contract with Provider Groups. Interested persons should call the Provider Information Hotline at (626) 299-5599 and request a list of CHP contract Provider Groups. Providers are welcome to contact any of these contractors and inquire about joining their network so that they can provide services to CHP Members.

PROVIDER COMPLAINTS/GRIEVANCES/APPEALS

Resolution of Provider Questions, Problems and/or Other Concerns

If a provider has a question, problem and/or other concern, the CHP provider's first responsibility is to contact their Independent Physicians Association/Medical Group (IPA/MG) or DHS facility, because the CHP provider is either a contractor/ employee of the IPA/MG or DHS facility.

If the CHP provider is dissatisfied with the IPA/MG's or DHS facility's response or the problem concerns the IPA/MG or DHS facility, the provider may call the CHP Provider Relations Information Line at (626) 299-5599. A CHP Provider Relations Representative will either resolve the issue to the provider's satisfaction or refer the provider to the CHP Grievance Coordinator to file a grievance.

CHP Providers have the right to file a formal grievance in accordance with CHP Policy and Procedure 13.3, Provider Informal Complaints and Formal Grievances (see **Exhibit W**). If the provider's grievance was received in person, the CHP provider is requested

PROVIDER COMPLAINTS/GRIEVANCES/APPEALS (continued)

to complete a Provider Grievance Form (**Exhibit X-1**). If the grievance was received by telephone or in writing, a CHP Grievance Coordinator may complete a Provider Grievance Form on the provider's behalf.

Informal Complaint:
A complaint that is resolved to the provider's satisfaction within seven (7) calendar days from the receipt of the complaint.

If the provider's question/complaint is received in person, in writing or over the telephone, the CHP Grievance Coordinator responds orally within seven (7) calendar days.

Formal Grievance:
A formal grievance is a complaint, which cannot be resolved to the provider's satisfaction within seven (7) calendar days from the receipt of the grievance and must be resolved within 30 calendar days.

If the provider's grievance was received in person, the provider is requested to complete a Provider Grievance Form. If the grievance was received by telephone or in writing, the CHP Grievance Coordinator completes a Provider Grievance Form on the provider's behalf.

Complaints or grievances can be received from the provider in writing, in person, fax or by telephone and can be communicated directly to either CHP**:**

The CHP Grievance Coordinator may assist CHP providers in filing grievances, including assistance with completing a grievance form and referral of the grievance to the CHP Grievance Coordinator. The CHP Grievance Coordinator will record the formal complaint/grievance using the Provider Complaint/Grievance Log (**Exhibit X-2**). Regardless of the method utilized to file the provider's formal grievance, the provider will receive an acknowledgment letter (**Exhibit X-3**) within five (5) calendar days for standard grievances and 24 hours for expedited.

If the CHP provider is dissatisfied with a decision involving clinical issues, the CHP Grievance Coordinator will consult Medical Administration immediately upon receipt of the grievance to determine the clinical issue.

PROVIDER COMPLAINTS/GRIEVANCES/APPEALS (continued)

Complaints or Grievances Received by CHP

If the provider telephones or appears at CHP in person with a complaint or grievance, a CHP Grievance Coordinator will explain the difference between an informal complaint and a formal grievance. If the provider wishes to file a formal grievance, the CHP Grievance Coordinator will give the provider detailed instructions about filing a grievance, the grievance and appeal process, the Ombudsman program, and the option of filing a State Fair Hearing Request with the SDHS and/or filing an appeal with the DMHC. The CHP Grievance Coordinator will assist providers in filing grievances, including assistance with completing a grievance form. The CHP Grievance Coordinator will record the formal grievance using the Informal Complaint/Grievance Log.

Regardless of the method of filing for the provider's formal grievance, the provider will receive an acknowledgment letter within five (5) days.

Resolution Process

A resolution letter (**Exhibit X-4**) will be mailed to the provider within 30 calendar days of the initial receipt for standard grievance and 72 hours for expedited/urgent grievance along with a copy of the CHP Grievance Appeal process (Exhibit W, Attachment VI). This letter will include information about the CHP provider's right to submit a grievance appeal and a copy of the CHP grievance appeal process.

Provider Grievance Appeal Process

If the CHP provider is still dissatisfied with the grievance resolution, a grievance appeal may be initiated at the level of CHP or DMHC, please reference the Provider Grievance Fact Sheet (Exhibit W, Attachment VI).

Upon receipt of a grievance appeal, the CHP Grievance Coordinator will immediately notify the CHP Grievance Coordinator who will log and date the appeal for tracking purposes. The CHP Grievance Coordinator will send an acknowledgment letter to the provider within five (5) calendar days for standard appeals and 24 hours for expedited.

For clinical grievance appeals, the CHP Grievance Coordinator will notify the Clinical Grievance Coordinator of the appeal on the same day of receipt.

PROVIDER COMPLAINTS/GRIEVANCES/APPEALS (continued)

Extension of the Grievance Process Period

A grievance process period can be extended through the following steps. In order to enhance the opportunity to resolve the grievance satisfactorily, a provider, a representative of the CHP Member, or a provider on the Grievance Review Subcommittee may request a ten (10) day extension of the grievance time period at any stage in the process. Such extensions shall specify the time period for the respective steps in the resolution process and may include postponement of the Grievance Review Subcommittee Hearing. An extension in one stage of the process will not affect the time allotted for subsequent stages. Extensions are granted on a case-by-case basis in ten (10) day increments.

Extension requests will be approved by the chair of the respective committee. Upon agreement of the extension period, the CHP Grievance Coordinator will notify the grievant and appropriate committee of the extension period and other requirements necessary to resolve the grievance.

IMR Review

A provider may request an expedited review in the following circumstances:

a) The Member's doctor has recommended a health care service as *medically necessary* and it was denied; or
The Member received *urgent* care or *emergency* services that a provider determined was necessary and payment was denied; or
The Member was seen by a *network* doctor or a PCP for the *diagnosis* or treatment of the medical condition (*even if the health care service was not recommended by a network provider).*

The *disputed health care service* has been denied, changed, or delayed by CHP based in whole or in part on a decision that the health care service is not *medically necessary*.

The Member filed a *grievance* with CHP and the service is still denied, modified, delayed, or the *grievance* remains unresolved after 30 days.

The dispute will be submitted to a DMHC medical specialist if it is *eligible* for an IMR. The specialist will make an independent decision of whether or not the care is *medically necessary*. The Member will receive a copy of the IMR decision from the DMHC. If it is decided that the service is *medically necessary*, CHP will provide the health care service.

PROVIDER COMPLAINTS/GRIEVANCES/APPEALS (continued)

If the grievance requires an expedited review, the Member does not have to participate in CHP's grievance process for more than three (3) days.

If there is an imminent and serious threat to the Member's health as the information is reviewed by an independent medical review organization (within 24 hours of approval of request review) the DMHC may waive the requirement that the Member follow CHP's grievance process.

Lack of Response by Provider and Suspension of a Grievance

The steps below are to be utilized by CHP for handling a lack of response by a provider who submitted a grievance.

When the acknowledgment letter for a formal grievance is returned unopened, the CHP Grievance Coordinator will attempt to obtain a current address and send a second notice/acknowledgment letter to the provider within five (5) working days of the return of the first letter.

If the second letter is undeliverable, the CHP Grievance Coordinator will attempt to determine the reasons for the failure to deliver the notice.

When no response to the second letter is received and the CHP Grievance Coordinator cannot reasonably expect delivery of a third letter, action on the grievance is to be terminated and the grievance is suspended.

The provider may reactivate the grievance within six (6) months. If a suspended grievance is not reactivated within six (6) months, the grievance will be terminated. If a grievant wishes to reactivate the grievance after six (6) months from the time it has been suspended, the CHP Grievance Coordinator may authorize re-activation if a reasonable cause for the delay can be shown.

Processing Arbitration Requests

The procedures shown below are to be followed in responding to an Arbitration Request:

Upon receipt of an notification that a Arbitration has been requested, the CHP Grievance Coordinator will log the date of receipt, the case number, the grievant's name and a brief summary of the issues of the case on the Arbitration summary log. A file under the grievant's name will be opened and retained in the CHP Grievance Coordinator's Arbitration files.

PROVIDER COMPLAINTS/GRIEVANCES/APPEALS (continued)

If the Arbitration relates to a decision made by CHP, the CHP Grievance Coordinator will forward all pertinent information to the appropriate department, which will draft CHP's position paper for review prior to the hearing date.

When the CHP Grievance Coordinator is notified of the date and time of the Arbitration Hearing, he/she will enter this information on the Arbitration Summary Log, notify the staff person responsible for developing CHP's position paper for this case. The position paper will be completed at least three (3) days prior to the date of the hearing. A copy of CHP's position paper will be forwarded to the CHP Grievance Coordinator, who will circulate it to a designated Board of Governors representative, the CEO, Executive Director of Operations, CIO, CFO and CMO. A copy will be forwarded to legal counsel.

Once the position paper has been reviewed and approved, the CHP Grievance Coordinator will send a copy to the Arbitration Officer and log the date it was sent on the Arbitration Summary log.

The CEO will determine who, if anyone, will appear at the hearing. In addition, CHP will provide copies of all pertinent information including CHP's investigation materials, medical records, and copies of all correspondence with the provider and any other information used by CHP in reaching its decision and/or position.

When a finding on the final disposition of the case is received from the Arbitrator Officer, the CHP Grievance Coordinator will enter a summary of the finding on the Arbitration summary log along with the date of receipt. The appropriate CHP Grievance Coordinator will provide copies of the final disposition of the case to all concerned parties.

TREND ANALYSIS, REPORTS, AND CORRECTIVE ACTIONS

To assist with and ensure improvement in provider services and provider satisfaction, trend analysis, report generation, and corrective action plan development and implementation are routinely conducted.

REPORTS

CHP is required to provide information and reports on classification and time frame for resolution of all Grievances.

REPORTING SUSPECTED FRAUD

CHP Anti-Fraud Program

CHP has an anti-fraud program which is outlined in its Anti-Fraud Plan. The strategy of the CHP Anti-Fraud Program is to identify and reduce costs to the Plan, providers, Members, enrollees, and others caused by fraudulent activities, and to protect consumers in the delivery of health care services though the timely detection, investigation, and prosecution of suspected fraud.

Common Fraud Schemes in Managed Care*

Administrative/Financial
Falsifying credentials
Billing fee-for-service (FFS) for capitated services (double billing)
Accepting kickbacks for referrals of sicker patients to FFS specialists
Conducting improper enrollment and disenrollment practices
- Attracting healthy patients or refusing to enroll sicker patients
- Persuading or forcing sicker patients to disenroll
- Falsifying medical exemptions

Services/Encounter
Falsifying encounter data
Misrepresenting services provided to meet quality of care standards
Billing for services/supplies not provided
Upcoding and unbundling charges

Denial of Services/Access
Excluding distinct groups of beneficiaries (e.g., patients with chronic conditions or terminal illness)
Engaging in under-utilization
Regularly denying treatment requests and specialist referral without regard to legitimate medical evaluation.

Subscriber Issues
Falsifying eligibility application
Using another person's HFP identification card to obtain medical care
Falsifying/altering prescriptions
Misrepresenting medical condition
Failing to report third party liability

(*Common Fraud Schemes in Managed Care was prepared by the L.A. Care Health Plan for the Plan Partner's Medi-Cal Managed Care anti-fraud brochure.)

REPORTING SUSPECTED FRAUD (continued)

How To Report Fraud

CHP CONTRACT PROVIDERS, THEIR STAFF, OR A CHP PLAN MEMBER:

When contract providers, their staff, or some Plan Members suspect or discover fraud (e.g., misuse of a Plan Member's card), they are required to report the activity either by phone, in writing or in person within 24 hours of such discovery.

May Be Reported by Phone (callers may remain anonymous) to either:

The SDHS Medi-Cal Fraud Hotline at (800) 822-6222; or

The L.A. Care Compliance, Fraud & Abuse Hotline at (800) 400-4889; or

The Los Angeles County – Fraud Hotline at (800) 544-6861, 24 hours a day, 7 days a week; or

The CHP Interim Compliance Officer at (626) 299-5328; or

May be Reported in Writing or in Person to either:

X Office of County Investigations (OCI)
1000 S. Fremont Ave., Bldg. A-9 East, First Floor
Alhambra, CA 91803-4737
fraud@auditor.co.la.ca.us, or

X Community Health Plan Interim Compliance Officer
1000 S. Fremont Ave., Bldg. A-9 East, 2nd Floor
Alhambra, CA 91803-8859
rmathias@ladhs.org

CHP DHS PROVIDERS AND ALL DHS STAFF FRAUD REPORTING REQUIREMENTS:

When CHP DHS providers or their staff suspect or discover fraudulent activity, they are required to follow the specific anti-fraud procedure for that specific DHS facility site.

For fraud issues involving CHP Members or providers, the initial step for County employees is to discuss it with their immediate supervisor, unless the suspected fraud involves the supervisor. If so, contact the Facility Compliance Officer. If the supervisor agrees that fraud is suspected, the Facility Compliance Officer must be notified. Department personnel making referrals by telephone or in person to the Facility Compliance Officer should be prepared to report the following pertinent case information:

- Date and time of call
- Name or location of facility
- Any relevant information concerning the allegations
- Names of staff, providers, or Plan Members involved
- Name of caller (unless anonymous), and
- Contact phone number for caller

Unless requested by either DHS Inspection & Audit Division or the Auditor - Controller, all DHS staff are instructed:

NOT to investigate the matter

NOT to contact any individual(s) under suspicion

NOT to disturb or otherwise compromise any physical evidence

Because of the sensitive nature of criminal investigations, departments should avoid taking any action that will alert the suspect individual(s) to any impending investigation.

CULTURAL AND LINGUISTIC - SECTION 11

Cultural and Linguistic Services

Objective: To ensure that CHP Members have access to timely interpreter services at medical and non-medical points of contact that meet their cultural and linguistic needs.

Guidelines: A CHP Member shall not experience unreasonable delays in receiving appropriate culturally competent and interpreter services when the need for such services is identified by providers or requested by the Member.

A Member is to be advised of the availability of and right to use free interpreter services and is not required to provide her/his own interpreters. If requested by the Member after being informed that she/he has the right to use free interpreter services, a family Member or friend may be used as an interpreter. No minors will be used for interpretation.

The use of a family Member or friend, acting as interpreter, should not compromise the effectiveness of services nor violate the Member's confidentiality. Member request or refusal to accept the services of a qualified interpreter is to be clearly documented in the Member's medical record.

Interpreter services shall be available on a 24-hour basis and accomplished by on-site interpreters, bilingual and multilingual membership staff, assigning a Member to a provider able to provide services in the Member's language, and/or utilization of contracted interpreter services. Telephone interpreter services will supplement face-to-face interpreters.

The effectiveness of the Plan's cultural and linguistic program is evaluated through analysis of grievances regarding communication or language problems, and assessment of Member satisfaction surveys with regard to the quality and availability of interpreter services.

Members may submit grievances when dissatisfied with Plan services including when cultural and linguistic needs are experienced as inadequate.

Cultural and Linguistic Services (continued)

Interpreter services are to be provided at key medical and non-medical points of contact to limited English proficient (LEP) Members.

Definition(s): Limited English proficient Members: Those Members who cannot speak, read, write or understand the English language at a level that permits them to interact effectively with health care providers and social service agencies.

Medical points of contact include a face-to-face or telephone encounter with providers (physician, physician extenders, registered nurses, pharmacist, or other personnel) who provide medical or health care services and/or advice to Members.

Non-medical points of contact include Member services, appointment services, and Member orientation sessions.

At key points of contact, translated signs are to be posted informing Members of the availability of free interpreter services.

Linguistic services include the following:

- Interpreters
- Translated signage
- Translated written materials
- Referrals to culturally and linguistically appropriate community services programs.

Member Informing Materials

Objective: To ensure that CHP Members receive culturally sensitive and linguistically appropriate informing materials.

Guidelines: CHP Members are provided with written translated informing materials containing essential information regarding access to and usage of Plan services.

Using CHP enrollment information, Members whose primary language is a threshold language are identified at least monthly by CHP Managed Care Information System (MCIS). Informing materials are translated by

Member Informing Materials (continued)

qualified translators and provided to Members on a routine basis. The following CHP materials are made available in threshold languages (For threshold languages, please refer to Exhibit U, Attachment A):

1. Member Handbook,
2. Evidence of Coverage and Disclosure,
3. Provider directory,
4. Pharmacy directory,
5. Marketing materials,
6. Member notification letters (e.g., grievance, denial and provider change letters),
8. Member surveys,
9. Newsletters, and
10. Informational notices.

Plan facility signage will be translated into threshold languages.

FINANCE AND CLAIMS PROCESSING - SECTION 12

MEDICAL CLAIMS ADJUDICATED BY THE CHP

The CHP adjudicates medical claims on behalf of its contract providers for emergency room related and inpatient services received at a non-capitated facility. All other claims are processed by the capitated provider having the financial risk for such services. The CHP adjudicates claims within the timeframes established by Section 1371 of the Knox-Keene Act and follows the claims settlement practices and dispute resolution mechanism of Title 28, Sections 1300.71 and 1300.71.38, respectively.

REINSURANCE/STOP LOSS COVERAGE

Contract providers are responsible for the total cost, except as stated below, for care rendered to Members enrolled with its providers under the terms of their CHP contract. Contract providers are required to obtain reinsurance for the cost of providing covered services subject to the conditions specified under California Code of Regulations, Title 22, Section 53252.

The cost of the contract provider's reinsurance/stop loss coverage is the contract provider's sole financial responsibility.

Contract providers shall ensure that the CHP has a recent and updated copy of the reinsurance/stop loss insurance policy, and shall promptly notify the CHP of any material changes in its coverage.

CAPITATION PAYMENTS

Capitation payments shall be rendered the month following the capitated month of enrollment. Capitation shall be paid in accordance to the negotiated rates set forth in the provider contracts.

The CHP may retroactively adjust the contractor's payments on a periodic basis to reflect changes in the Plan's enrollment due to supplemental enrollments and disenrollments. Adjustments to contractor's capitation payments will be clearly identified in the remittance advice sent by the CHP.

Based on the "Division of Financial Responsibility for Health Care Services" matrix incorporated in each provider contract, the Plan will offset the cost of provider-responsible claims paid by the Plan on behalf of a contractor from its capitation payments. Additional information regarding claim deductions, may be obtained by contacting CHP's Capitation Unit at (626) 299-3335 or addressing your question(s) to:

CAPITATION PAYMENTS (continued)

Fiscal Programs
Community Health Plan - Finance
Attention: Capitation Unit
1000 S. Fremont Avenue
Building A-9, East 2nd Floor, Unit 4
Alhambra, CA 91803-8859

In order to facilitate the Capitation Unit's response to your question, please provide the following information:

Deduction period
Claim number
Patient's name
Expense charged and
Explanation of the inquiry

The Capitation Unit will research your question and provide a written response.

REFERRALS TO OUT-OF-AREA FACILITIES

If a Plan Member is serviced at an out-of-area Hospital and/or other provider for emergency, specialty, and inpatient care, the contract provider shall refer that out-of-area provider to the CHP for authorization as indicated herein. The CHP is financially liable for these services; therefore all requests for authorization for these services shall be deferred to the CHP. In the event that contract providers and/or contractor's network providers fail to follow this provision, the contract provider shall be financially responsible for the services authorized by the contract provider and/or the contractor's network providers. The contract provider's capitation payment will be adjusted to offset the cost of these provider-responsible claims paid by CHP on behalf of the contract provider.

COLLECTION OF CHARGES FROM PLAN MEMBERS

No Provider Group will, in any event, submit a claim to demand or otherwise collect reimbursement from a CHP Member or persons acting on behalf of a Member for any service provided, except to collect any authorized co-payments, third party payments in accordance with California Code of Regulations Title 22, Section 53222(a) and payment for any services provided pursuant to Title 22, Section 53210(d).

DELEGATION OF CLAIMS PROCESSING TO CONTRACT PROVIDERS

A slightly higher capitation rate will be paid to contract providers that have received written authority to adjudicate claims currently paid by CHP. These claims include emergency and inpatient services rendered by out-of-plan or other CHP network providers.

In order to receive this delegated authority and higher capitation rate, "full risk" providers must submit a written request and be able to demonstrate ability to meet the following preconditions:

- Evidence of financial viability
- Evidence of reinsurance coverage
- Compliance with encounter data reporting requirements
- Evidence of appropriate infrastructure and policies and procedures to assure the ability to comply with Section 1371 of the California Health and Safety Code [Assembly Bill (AB) 1455]
- Evidence of an acceptable utilization and management program and applicable policies and procedures
- Fully executed contract and/or amendment(s) with CHP

If the claims processing function is performed by a legal entity other than the contract provider, the provider shall submit a copy of the contract between the provider and the claims processing organization to DHS' Centralized Contract Monitoring Division (CCMD).

Prior to approving a request for delegation authority, CCMD and CHP's Medical Administration Division may conduct a site visit. Additional information regarding the delegation of claims processing may be obtained by calling CCMD at (323) 869-7030.

FINANCIAL VIABILITY

Provider Groups must maintain adequate financial resources to carry out contractual obligations. Periodically, CHP may request information to monitor and substantiate the Provider Group's financial viability. This information may include, but is not limited to the following:

- Tangible Net Equity
- Working capital trends and related ratios
- Profit and loss trends
- Enrollment growth
- Administrative costs incurred by the Provider and affiliates

FINANCIAL VIABILITY (continued)

Quarterly and annual financial reports prepared in accordance with generally accepted accounting principles.
Copies of any financial reports submitted to any other public or private organization, if it differs in content from any report already submitted to the CHP

AB 1455 COMPLIANCE

AB 1455 amended Section 1371 of the California Health and Safety Code, effective January 1, 2004, to require health plans, capitated providers, and organizations responsible for adjudicating health plan Member service claims to: a) timely file, acknowledge and reimburse a complete and accurate claim; and b) have an established provider dispute resolution process.

Timely File, Acknowledge and Reimburse a Complete and Accurate Claim

All capitated providers, or their contracted claims processing organizations which have been delegated the claims adjudication function by the CHP, are required to timely file, acknowledge receipt and reimburse a complete and accurate claim in accordance with the new regulations. In order to assure compliance, the CHP requires delegated providers to submit a "Quarterly Claims Settlement Practices Report", which is due to the CHP within thirty (30) days of the close of each calendar quarter.

Provider Dispute Resolution Process

The California Code of Regulations, Title 28, Section 1300.71(q)(1) and (2) require providers to develop and administer a provider dispute resolution process. Delegated providers are required to submit to the CHP annual reporting for claims payment and dispute resolution mechanisms, which cover the period of October 1st through September 30th, by December 15th or 75 days after the close of the reporting period.

The DMHC has issued regulations at California Code of Regulations, Title 28, Sections 1300.71 and 1300.71.38, to implement these changes. The regulations can be accessed on the DMHC website at:
http://www.dmhc.ca.gov/library/regulations/title28/html/title28.htm

RECORDS, REPORTS AND INSPECTION

Records

Provider Groups will maintain all books, records and other pertinent information that may be necessary to ensure the Provider Group's compliance with its CHP contract for a period of seven (7) years from the end of the fiscal year in which its contract with the CHP terminates. These books, records, and other information must be maintained in

RECORDS, REPORTS AND INSPECTION (continued)

accordance with generally accepted accounting principles, applicable state laws and regulations, the DMHC, and the SDHS. These books and records will include, without limitation, all physical records originated or prepared pursuant to the performance under the contract including but not limited to:

Working papers
All reports submitted to SDHS, DMHC, the U.S. Department of Health and Human Services (DHHS), and the Department of Justice (DOJ)
Financial records, including all books of account, encounter data, all medical records, medical charts and prescription files, and any other documentation pertaining to medical and non-medical services rendered to Plan Members.
5. Hospital discharge summaries
6. Records of Emergency Services and other information as reasonably requested by the CHP, L.A. Care, SDHS, DMHC, DHHS, and the Bureau of Medi-Cal Fraud as necessary to disclose the quality, appropriateness, and/or timeliness of health care services provided to Plan Members under the CHP contract, the Knox-Keene Act, the laws governing the Medi-Cal program, SDHS and DMHC.
7. Provider Group subcontracts.
8. Reports from other contracted and non-contracted providers.
9. Any reports deemed necessary by the CHP, L.A. Care, SDHS, and DMHC to ensure compliance by the CHP with the requirements of L.A. Care, DMHC and SDHS.

Each Provider Group will maintain all books and records necessary to disclose how the Provider Group is fulfilling and discharging its obligation under its CHP contract, and its responsibilities as defined by L.A. Care, DMHC and SDHS. These books and records will be maintained to disclose the following:

The quantity of covered services provided
The manner and amount of payment made for those services
The persons eligible to receive covered services
The manner in which the Provider Group administered its daily business
The cost of administering its daily business

Inspection of Records

Provider Groups will allow the CHP, L.A. Care, DMHC, SDHS, DHHS, the Comptroller General of the United States, DOJ, the Bureau of Medi-Cal Fraud, and other authorized State and federal agencies to inspect, evaluate, and audit any and all books, records and facilities maintained by the Provider Group and its providers as they pertain to services rendered under the Provider Group's contract with the CHP, at any time during

RECORDS, REPORTS AND INSPECTION (continued)

normal business hours subject to the confidential restrictions discussed in the Provider Group's contract.

Retention of Records

The Provider Groups' books and records must be maintained for a minimum of seven (7) years from the end of the fiscal year in which the Provider Group's contract with the CHP expires or is terminated. However, in the event the Provider Group has been duly notified that DMHC, SDHS, DHHS, DOJ, or the Comptroller General of the United States have initiated an audit or investigation of the CHP, L.A. Care, or the Provider Group, the Provider Group will retain these records for the greater of the above time-frame or until the matter under audit or investigation has been resolved.

Financial Statements

Provider Groups must supply the CHP with a copy of its annual financial statements within one hundred twenty (120) calendar days after the Provider Groups' year-end. The Provider Group will also provide the CHP with copies of its quarterly financial statements within forty-five (45) calendar days after the end of each quarter. The quarterly financial statements need not be audited.

Upon request, each Provider Group must obtain and provide the CHP with quarterly and annual audited financial statements of any of its providers, to the extent that the providers prepare such financial statements.

Each Provider Group will permit its independent accountant to allow representatives of the CHP, L.A. Care, SDHS and the DMHC to inspect all working papers related to the preparation of the audit report, including all notes, computations, work sheets and rough drafts.

THIRD PARTY LIABILITY

Contract providers in the CHP's network shall not make a claim for recovery of the value of covered services rendered to a CHP Member when such recovery would result from an action involving the tort liability of a third party or casualty liability insurance, including Workers' Compensation awards and uninsured motorists coverage.

Providers shall identify and notify the CHP's Chief Executive Officer (CEO) or designee within ten (10) days of the discovery of cases in which an action or potential action by a CHP Member involving a tort liability or Workers' Compensation of a third party could result in recovery by the recipient of funds to which the CHP has lien rights under Article 3.5, Chapter 7, Part 3, Division 9, of the Welfare and Institutions Code.

THIRD PARTY LIABILITY (continued)

If the CHP requests payment information and/or copies of paid invoices/claims for covered services to an individual CHP Member, the provider shall deliver the requested information to the CEO or designee within ten (10) days of request.

The provider shall calculate the value of the covered services at the usual, customary, and reasonable rates made to non-Plan patients for similar services or out-of-plan providers for similar services.

To assist the CHP in exercising its responsibility for such recoveries, providers are to supply the following information:

Member name
14-digit Medi-Cal number
Social Security number
Date of birth
Provider name if different from contract provider
Date(s) of service
Diagnosis code and/or description of illness/injury
Procedure code and/or description of services rendered
Amount billed by provider
Amount paid by other health insurance to provider (if applicable)
Amount and date paid by provider or out-of-plan provider (if applicable)
Date of denial and reason(s) (if applicable)
Date of injury.

The provider shall identify a contact person who can provide any additional information regarding third party liability to the CEO or designee upon request. Also, if the provider receives any requests by subpoena from attorneys, insurers or beneficiaries for copies of bills, claims or other related information, the provider shall supply CHP and L.A. Care with a copy of any document(s) released as a result of such request with the requestor's name, address and telephone number within five (5) days of compliance with the request.

MARKETING - SECTION 13

Overview

Marketing involves those activities that enhance awareness and understanding of the CHP and its affiliation with L.A. Care and that help to increase enrollment and Member retention in CHP.

CHP plans and implements independent marketing activities in the communities it serves as well as participates in collaborative activities with L.A. Care and other plans affiliated with L.A. Care.

Prior to implementation, all non-collaborative activities and marketing materials must be reviewed and approved by L.A. Care and the SDHS.

Marketing Presentations

To ensure compliance with State regulations, marketing presentations made on behalf of CHP must include a complete explanation of the following:

- The State's Two-Plan Model for Medi-Cal Managed Care and the roles of L.A. Care and the CHP
- Scope of services
- Access to and availability of services
- Restrictions on health care services provided
- Type of membership identification which authorizes Members to obtain services
- The fact that Members shall obtain all covered health care services rendered in non-emergency situations through CHP providers
- The fact that health care services required in an emergency may be obtained at all times from specified CHP providers or from non-CHP providers, if necessary
- How to access routine and emergency services
- Enrollment, disenrollment and role of Health Care Options in these processes.
- Member grievance procedures
- The fact that enrollment is subject to a verification and processing period of 15 to 45 days in length
- Description of managed care benefits
- Mandatory and voluntary aid codes
- Medi-Cal eligibility determination/redetermination process

MARKETING (continued)

To market CHP, staff Members are required to complete at least 16 hours of marketing training, pass an SDHS Marketing Representative Certification Examination and be certified by SDHS. Terminations and/or resignations of marketing staff must be reported to the CHP Marketing Manager within 48 hours of the action. CHP will notify L.A. Care, which will report the action to SDHS. An exit interview will be scheduled for terminating or resigning staff Members. In the event a termination is due to an instance of misrepresentation or marketing guidelines violation, the termination is to be reported to the CHP Marketing Manager the same day it occurs. CHP, in turn, will report the termination to L.A. Care, which will notify the State.

The CHP is responsible for monitoring its providers' outreach efforts and marketing material usage and distribution. CHP must immediately notify L.A. Care regarding any marketing violations by providers. L.A. Care will 1) provide written notification to the violator requesting a cease of use and warning of impending action for failure to follow policy, and 2) determine liable party(ies) and penalty to be levied.

Off-Site Outreach Activities

Outreach activities by the CHP at locations other than Los Angeles County DHS facilities and administrative offices, and CHP contract provider sites will be permitted when prior approval has been obtained from the CHP Marketing Manager, L.A. Care and SDHS.

Off-site activities may occur at organized community or neighborhood health fairs in a public place if two or more prepaid health plans or primary care case management groups are participating, or if the sponsor of the fair invites the CHP or its provider(s). A copy of a signed letter of invitation must be submitted with the authorization forms requesting approval.

Effective May 1, 1996, off-site locations may include, but are not limited to, health fairs, community group meetings, schools, and social service agencies. Off-site activities are prohibited at food stamp and check cashing locations, supermarkets, laundromats and shopping malls (unless an "organized health fair" is held in a mall.)

A request for approval must be submitted within 70 days prior to the event on the L.A. Care and SDHS approved Descriptive Layout for Off-Site Activity form accompanied by a signed Authorization to Conduct Activities form (Exhibit EE) and, if necessary, the abovementioned signed letter of invitation. The two forms must be faxed or mailed to CHP, Marketing Section, 1000 South Fremont Avenue, Building A-9 East, 2nd Floor, Unit 4, Alhambra, California 91803-8859, Fax: (626) 299-3352.

MARKETING (continued)

L.A. Care and SDHS will provide a written response immediately upon notification of approval. CHP Marketing Section maintains a copy of the approved agreement.

Marketing Materials

Marketing materials include but are not limited to marketing brochures, flyers, mailers and similar printed material; print and broadcast advertisements; press releases; provider lists; and marketing presentations. This includes materials distributed at off-site outreach activities and materials distributed in providers' offices.

Prior to their use or implementation, Provider Groups and/or providers must submit all marketing materials to the CHP Marketing Section, which is responsible for submitting them to L.A. Care and SDHS for approval. The approval process may take as long as 70 days.

Use of the CHP Logo on Marketing Materials must comply with the Standards established in CHP Policy #3.1.

Use of the CHP logo in marketing materials must comply with standards established in CHP Policy No. 3.7. All materials directed at Medi-Cal beneficiaries must identify the CHP as an affiliate of L.A. Care; must incorporate the L.A. Care logo according to the specified graphic standards for its use; and must be ethical, culturally sensitive and linguistically competent. The following procedures apply for receiving approval of proposed marketing materials from providers:

1. Provider Groups and/or providers are to submit one copy of materials to the CHP Marketing Services Unit {fax number (626) 299-3352}.

    a. If materials are general in nature (i.e., materials that will be used to reach the Medi-Cal population, but do not use the word "Medi-Cal," do not make any association with this audience, and do not use CHP or L.A. Care names), and the Provider Groups and/or provider contracts with more than one Plan Partner, only one set need be submitted to CHP.

    b. If materials contain the names or logos of more than one Plan Partner, the Provider Group and/or provider must submit a copy of materials to each Plan Partner mentioned for review and approval.

MARKETING (continued)

Submitted materials must be final and clear copies that are legible and contain the original copy. Rough ideas are not acceptable.

3. CHP will forward all provider-submitted materials, with an explanation of their intended uses, to L.A. Care for review and approval, and will notify the initiating provider of L.A. Care's response when it is received.

DATA EXCHANGE - SECTION 14

OVERVIEW

The Managed Care Information Systems (MCIS) Division provides information management services and support for the CHP to comply with L.A. Care and State of California Department of Health Services' (SDHS) Medi-Cal Managed Care Program and reporting requirements. Such activities include systems support, as well as computing and network services, to facilitate the flow of information and data to and from CHP and its agencies for daily operations.

SERVICES AND SUPPORT

The services and support provided by MCIS include, but are not limited to, the following:

- Process Medi-Cal beneficiary data received from L.A. Care at the beginning of every month, with supplemental data received throughout the month, update Member enrollment and eligibility status; provide L.A. Care with Member enrollment and eligibility confirmation data.

- Generate Member eligibility reports and statistics for CHP on a monthly basis.

Provide Member eligibility information to CHP's pharmacy adjudicator for verification of active enrollees for the release of prescription drugs.

Provide new Member enrollment and transfer information to CHP's fulfillment vendor for distribution of new Member enrollment packets and Member transfer materials.

Provide active Member enrollment information to call center vendor for after-hours eligibility verification services.

Maintain CHP's provider network database and provide L.A. Care with monthly updated provider information.

Oversee collecting and processing of inpatient, outpatient, long-term care, and pharmacy encounters from contracted and Department of Health Services (DHS) providers. Submit encounter data to the regulatory agencies.

Generate ad hoc reports and statistics for CHP's functional units (Administrative Office, Financial Services Division, Marketing/Customer Services, Medical Administration, and Provider Relations) to comply with L.A. Care and SDHS' reporting requirements.

SERVICES AND SUPPORT (continued)

- Coordinate connectivity and access to the information management system for registering Members, verifying Member eligibility, updating and maintaining Member status, processing claims, and other functions.

- Provider application tracking and systems training for the information management system.

- Provide research and analysis for technological solution to automate and streamline business processes.

- Coordinate implementation of Health Insurance Portability and Accountability Act (HIPAA) related Transaction and Code Sets.

ENCOUNTER DATA SUBMISSION

CHP, as a health plan, must collect encounter data for operation and regulatory reporting requirements. All inpatient, outpatient, and long-term care encounter data shall be submitted and include, but may not be limited to, the following:

- Hospital bed days by type
- Skilled nursing facility bed days by type
- Ambulatory by type and place of service
- Emergency room diagnosis and procedure codes
- CHDP (PM-160) encounters
- Outpatient diagnosis and procedure codes
- Inpatient diagnosis and procedure codes

For contracted providers, the encounter data must be submitted in standard hard copy form (i.e., HCFA-1500, UB-92, etc.) stamped with “ENCOUNTER DATA ONLY” or submitted electronically to CHP’s contracted encounter data clearing house vendor each month. For specifics on how to submit to the clearing house vendor, contact the MCIS encounter data liaison.

For DHS providers, the encounter data must be submitted via the Affinity-to-PMS data extract.

AUTOMATIC ASSIGNMENT

For Member(s) who do not select a primary care practitioner (PCP), the following guidelines are used for automatic assignment according to CHP protocol:

Pre-Existing Relationship with an active PCP (within the last three months)
Family Composition
Proximity to Home
PCP Member Capacity
Language
Age/Gender
Default to Traditional and Safety Net Providers, DHS Strategic Partners Providers, or Primary Care Providers at random

HOW TO CONTACT MCIS

For more information regarding encounter data reporting, please contact:

Encounter Data Liaison
Office: (626) 299-3321

For information on HIPAA Transaction and Code Sets, please refer to or contact:

Website: http://lachp.claimsnet.com

Email: LACHPTCS@ladhs.org

For all other information, please contact the Director of Managed Care Information Systems at:

County of Los Angeles, Department of Health Services
Managed Care Information Systems
1000 S. Fremont Avenue
Building A-9, East 2nd Floor, Unit 4
Alhambra, CA 91803-8859

Office: (626)299-3329
Fax: (626) 308-0492

HEALTH EDUCATION - SECTION 15

Overview

The OMC Health Education/Cultural and Linguistic Unit is charged with assessing, planning, directing and evaluating the health education, services and programs to meet CHP Member's educational needs.

OMC Health Education Program

The OMC Health Education Program is a two-tier system. The first tier of the program is the responsibility of the Plan. The second tier of the program is delegated to the CHP primary care sites.

A. Plan's Responsibilities - Refer to CHP Policy 15.1, Provision of Health Education Services (Exhibit U):

1. CHP Members *HEALTH NEWS*
   The OMC Health Education/Cultural and Linguistic Unit is responsible for developing the *HEALTH NEWS* bulletin in English and Spanish. The bulletin is focused on educating Plan Members about preventive care and healthy lifestyles.

2. Consultation and Technical Assistance
   The OMC Health Education/Cultural and Linguistic Unit provides consultation and technical assistance to CHP providers on areas that include but are not limited to: patient education materials, health education program development, and health education resources.

3. Health Education Materials Development
   The OMC Health Education/Cultural and Linguistic Unit develops patient education materials as appropriate, based on health topics mandated by the California State Department of Health Services, and findings and recommendations from Group Needs Assessments.

4. Standards and Guidelines Development
   The OMC Health Education/Cultural and Linguistic Unit provides Plan-wide health education standards and guidelines.

HEALTH EDUCATION (continued)

5. Assessment of Members' Educational Needs
   The OMC Health Education/Cultural and Linguistic Unit works collaboratively with other Managed Care Organizations in identifying common health problems and establishes health education priorities based on Members' needs.

6. Oversight of the Plan Providers' Health Education Program
   The OMC Health Education/Cultural and Linguistic Unit is responsible for ensuring each primary care site meets minimum requirements in providing health education services to its Members.

B. Primary Care Site's Responsibilities:

1. Member Education
   Provide and coordinate patient education, counseling and referral services for Members with moderate and high-risk medical conditions to help ensure compliance with medical orders, prevent relapse or recurrence of disability and promote optimal health.

   Promote appropriate use of health care services to Members to minimize preventable illness, disease and emergency room visits.

   Develop health education process and outcome objectives of clinical preventive services, patient education and population-based education as well as criteria for monitoring health education programs and services in managed care plans.

2. Promote Appropriate Use of Managed Care Plan Services
   Assure that CHP Members are appropriately educated to increase their knowledge in accessing health care. Conduct comprehensive, culturally and literacy appropriate health education assessments to determine health practices, values, behaviors, knowledge, attitudes, and beliefs of target populations, barriers to accessing health care and educational needs of the Members.

   Provide culturally and linguistically appropriate education, information and outreach services about personal health behavior and health care to

HEALTH EDUCATION (continued)

ensure that all eligible persons are given the opportunity to enroll and maximize the utilization of health care services provided by CHP. Participate in quality improvement activities to assure that managed care services are culturally sensitive, linguistically appropriate, and emphasize health education and promotion.

Health Education and Promotion Materials

Each CHP primary care site should have at least one (1) of the following health education equipment items necessary to provide health education and promotion services and programs:

- Waiting room bulletin boards
- Pamphlet racks in waiting rooms and exam rooms
- Book shelves in nursing stations for health education standards and curricula
- Storage space for educational materials and supplies
- VCR on cart and/or in a designated area for education

CHP providers are encouraged to use health education materials provided by OMC Health Education/Cultural and Linguistic Unit. The ordering, purchasing, printing and distributing of health education and promotion materials are the responsibility of each individual primary care site unless otherwise provided by the OMC. CHP primary care sites should have an adequate supply of health education materials in English and other threshold languages (based on patient population served) at a literacy level of 6th grade or below. The current CHP threshold languages are English and Spanish. Technical assistance and consultation are available through the OMC Health Education/Cultural and Linguistic Unit upon request.

4. Health Education Functions

Each CHP primary care site is responsible for ensuring the following health education functions:

- Member must complete assessment of health behaviors and health education needs.
- Provider reviews the patient's individual health education behavioral assessment results (Review of the health behavior assessment should take place in the examination room by the

HEALTH EDUCATION (continued)

physician or allied health professional).
- Maintain the completed assessment form and results in the patient's medical record.
- Develop an individual health education plan:

  -- Prioritize and address health needs.
  -- Identify desired outcomes and risk status.
  -- Determine specific educational interventions, time lines, and procedures for follow up.
  -- Prioritize and address health needs.
  -- Consider the values, beliefs, and cultural traditions of the Member.
  -- Refer the Member to health education services which are not available at the provider site.

5. Cultural/Linguistic Services
   Providers are responsible for providing twenty-four (24) hour access to interpreter services for all limited English proficient Members seeking health services. In the event Members refuse to accept interpreter services, providers must document the refusal in the medical record. Providers should refer to the Cultural and Linguistics - Section 11 of this Manual for further information.

Health Education Programs

For available health education programs, the PCP may contact either the: Provider Group's Health Education Unit; or OMC Health Education Unit, call (626) 299-5575; or L.A. Care Health Education Unit, call (213) 694-1250 x4283.

EXHIBITS

EXHIBITS (continued)

EXHIBITS (continued)